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IMPRESSIONS OF THE LOUISVILLE CONVENTION

There was once a lung specialist who had done his work, played his part, and come to his last days. He sent for an eminent colleague, who hastened to his bedside, expecting to garner some of the fruits of the other man's rich experience.

"Doctor," said the sick man, "we've worked together for a good many years; I've known you on committees and in consultation. But there's one thing I've always wondered." He lowered his voice confidentially, "Doctor, I wish you'd tell me, What do you give for a cough?"

The Health Congress at Atlantic City fascinated and stimulated by its very size as well as by its content. After it, the convention at Louisville seemed almost a family affair, in spite of a registration of 4,800. Interest seemed centered more strongly than usual in the discussion of simple but important problems of the day's work, in discovering what other workers "give for a cough."

The formation of a Board and Committee Members Section of the N.O.P.H.N. was one of the long looked for and happy occurrences of the week; the professional members of the National Organization extend to this new section a most hearty welcome. Round table luncheons, teas, dinners and special meetings crowded the lay members' program, yet they found time to bring their enthusiasm and support to the professional meetings. In 1924 at the Detroit Convention Mrs. Chester Bolton questioned: "Will you not consider whether you cannot find a larger development for the future of your profession through a greater intimacy and an actual working hand in hand with the steadily increasing numbers of sympathetic and educated laity?" We public health nurses believe we are finding this greater intimacy and are rejoicing in it.

Dr. May Ayres Burgess showed us with great lucidity what we are doing in the production of nurses, and whither we are bound if we do not stop long enough to take stock and organize our efforts thoughtfully. The first report under the name of "Nurses, Patients, and Pocketbooks" is now obtainable and should be read by every member of the profession.

For the first time staff nurses had a meeting planned and conducted by themselves. At it were discussed such questions as the wisdom of higher education as a requirement for the public health nurse, and methods of supervision from the staff nurse's point of view. How valuable is this same point of view, every supervisor and executive director realizes. The staff nurses and the N.O.P.H.N. are to be congratulated that it is becoming audible.

Thoughtful papers, searching questions, chats with old friends, all these mass themselves into a whole, perhaps a more or less confused whole, by the end of a convention. We have heard opinions and problems. We have been asked questions that have set us pondering. And now we turn back to our own jobs. In a few days we shall be as involved in them as before, but for the moment we see them from a distance, and in something of their true proportion. We are sure we haven't done them very well in the past, and we are hopeful enough to believe that we are going to handle them better in the future. And so we separate and as each nurse settles back into her own work, the 1928 convention begins to be translated into action.

LAURA A. DRAPER

THE LARGER PROBLEM OF COMMUNITY NURSING *

By C.-E. A. Winslow, Dr. P.H.
Professor of Public Health, Yale School of Medicine

IT may be assumed that every craft and every profession was originally created by amateurs. An amateur is a lover, and new things are created only by love. The first carpenter must have been a man who loved the feel of smooth white timber and the neatness of a close firm joint. The first poet worshipped the hidden beauty of the universe and the mystic power by which words may reveal that beauty. The first nurse was a woman mastered by the power of pity and the joy of service. It was such motives as these which moved Fabiola, and the Sisters of St. Vincent de Paul, and the Deaconesses of Kaisersworth, and Florence Nightingale and Lillian Wald.

The spirit of the amateur must survive in all but it must be supplemented by that of the professional. Hospitals are still Houses of God but they must also be well managed business institutions with a complex and costly scientific equipment. Visiting nursing is no longer merely a charity to the poor but a social institution designed to serve all classes in the community. Private duty nurses practice a profession which requires a serious technical training (as Florence Nightingale said, "devotion is excellent, but one must have something to devote"); and it is a profession which must receive additional compensations to those offered by a sense of service rendered if its ranks are to be kept filled.

Nursing is then not only a vocation but a form of organized community service. It requires devotion, but it also requires intelligence, not only on the part of the individual but on the part of the group. You are responsible for a vital public utility,—the nursing care of the sick with its essential corollary of health teaching to the well; and the purpose of this address is to consider this community problem in its broadest aspects.

VOLUME OF NURSING SERVICE AVAILABLE

The profession of nursing in the United States, as distinct from the vocation of nursing, is about fifty years old. In 1880 there were but 15 schools of nursing in existence, turning out 157 graduates in that year. In 1926 there were 2155 schools with 17,522 pupils graduating. At the average rate of increase which took place between 1910 and 1920, this would give 202,000 graduate nurses in 1928, and Dr. May Ayres Burgess in her magnificent study for the Committee on the Grading of Nursing Schools estimates that the number of graduate nurses in 1965 would, at the present rate of growth, be 716,800.

The kind of nursing service rendered has changed in the past half century as phenomenally as its total volume. In 1880, patients, both in hospitals and homes, were with very few exceptions cared for by untrained attendants; and visiting nursing had only been thought of in two or three small municipal areas. To-day hospital nursing is carried on by a staff composed, for the hospitals of the country as a whole, of about equal numbers of graduates and students; but for hospitals maintaining training schools of one graduate to five or six undergraduate student nurses; home nursing on the private duty basis by a group at least half of whom are graduate nurses; while the whole beneficent machinery of public health nursing has grown up to fill needs hitherto undreamed of.

* Address given at the Joint Meeting of the National Biennial Nursing Convention, Louisville, Ky., June 5, 1928.

We have no exact information as to the way in which the nurses of the country are divided between these three fields. It appears probable, however, from Dr. Burgess' studies and from the figures available for the states of New York and Wisconsin that we have tended in the past to underestimate the proportion of nurses in public health work as compared with those in institutional service and private duty. If, on the basis of these data we estimate that 50 per cent of all graduate nurses are in private duty, 30 per cent in institutional service and 20 per cent in public health, we shall probably not be very far from the truth. Such an estimate would correspond for 1928 to 100,000 nurses in private duty, 60,000 in institution and 40,000 in public health service.

WHAT IS THE NEED FOR NURSING SERVICE?

So much for the available volume of nursing service. Now what of the need for such service? For, after all, even the most devoted of vocations can never escape from the operation of the basic laws of supply and demand. We have seen the trained nursing force of the country rise in fifty years to a point where there is one graduate nurse for every 600 persons in the population and more than one nurse for each physician. How far is this nursing force balanced by an equivalent need? Is there still a shortage of nurses? Or are there too many being produced by our 2000 training schools? Or has some mystic Malthusian law beneficently adjusted supply and demand?

For years it has been easy to obtain decisive answers to these questions,—any answers, indeed, that one desired,—ranging from an unqualified "no" to an unqualified "yes" in response to each query. No one, however, really knew, until Dr. Burgess, for the Committee on Grading of Nursing Schools, determined to find out. I think it is safe to say that few more significant contributions have been made since nurses first assembled for the discussion of their common problems. I must use for the solution of the problem now in hand certain of the broad conclusions which she has already formulated in her preliminary communications.

Those conclusions have already made it evident, beyond any peradventure, that the net result of the development of training schools and their eagerness to obtain pupils to staff their hospitals has more than overtaken the capacity of the community to consume, or at least to pay for, nursing service and has produced an over-supply of graduate nurses in private duty, wasteful from the standpoint of the public and tragic in its bearing upon some of the individual victims of the situation which has been created:

> Physicians, registries, public health agencies, hospital authorities and the nurses themselves all testify to the fact that there is no shortage but an over-supply of nurses in the field taken as a whole. During a typical March week, at the season when illness is at its height, one-seventh of the private duty nurses canvassed on a given day were unemployed. In spite of charges, which often seem to the patient exorbitant, the private duty nurse is unemployed for so large a fraction of the year that her earnings average less than $1,300, as against nearly $1,700 for the public health nurse and over $2,000 for the institutional nurse. Her hours are long when she is employed. Her work is arduous and her sickness rate high. As a result, only 55 per cent of the nurses now in this special field intend to stay in it, as compared with over 80 per cent of those in public health and institutional nursing.

Even in public health and institutional nursing there seems to be no general shortage in the number of available nurses. The superintendents of visiting nurse societies replying to the questionnaire of the Grading Committee report over five applicants for every vacancy. The majority of the training schools state that they have all the students they want. Nine-tenths of them have raised their entrance requirements and yet two-thirds report that student applications are on the increase.

If, however, we turn from the problem of quantity to that of quality we find a different picture. In the private duty field physicians report difficulty in securing nurses of the type needed to

deal with specially difficult cases; while in public health and institutional work there is a constant demand for women of higher qualifications, both personal and educational.

THE ESTIMATED NEED

In these two types of nursing service we can go beyond the study of present demand and estimate with reasonable accuracy the number of nurses really required to render adequate community service. In public health, the ratio of one nurse for every 2000 persons in the population is now well established as a minimum figure for sound community health work. Such a ratio would call for 60,000 public health nurses in the country as compared with some 40,000 now in service.

In the institutional field we may estimate the nursing needs somewhat as follows:

> On the basis of commonly accepted standards for general hospitals which maintain training schools, allow 400 beds per 100,000 population, with 48 graduate nurses and 160 pupil nurses; for tuberculosis, 50 beds, with 2 graduates and 8 pupil nurses; for mental disease and defect, 400 beds with 15 graduates and 70 pupils or attendants. This would give us per 100,000 population, a total need for institutional nurses of 65 graduate nurses and 238 pupil nurses, or for the country as a whole about 80,000 graduate nurses and 286,000 pupil nurses. This implies an increase of graduate nurses in institutional work from 60,000 at present to 80,000.

For private duty service there are now available about 100,000 nurses and this number is apparently too large as indicated by the amount of unemployment existing at the present time. While we may reasonably assume that public funds can, and will, ultimately be increased to render adequate service, there seems no way to alter the fact that the individual patient is not in position to employ as large a number of private duty nurses as are at present available. Furthermore, the development of hospitalization and of public health nursing in the future is likely to reduce substantially the need for private duty nursing of the present type. The community demand for such service is perhaps not likely to run much over 80,000.

Adding together these figures, 60,000 public health nurses, 80,000 institutional nurses and 80,000 private duty nurses, we get a total of 220,000, close to the present figure. For a population of 120 millions, the present total supply of graduate nurses plus one year's graduating class, would be nearly adequate, not only for actual but for ideal demands.

THE PROBLEM OF THE STUDENT NURSE

There is, however, one very serious problem raised by these computations. If we had an ideal provision of 4 general hospital beds per 1000 population and an equal number of beds for mental disease and defect, in the United States, with a commonly accepted ratio of one graduate for every 8 beds and one pupil for every 2.5 beds in the general hospitals, and one graduate for every 25 beds and one pupil for every 6 beds in the mental hospitals, we should require as noted above, 80,000 graduates and 286,000 pupils for the country. The number of graduates thus indicated is reasonable, the number of pupils is manifestly absurd,—being about four times the figure needed to keep the supply of graduates at about the saturation level. Of course this calculation is based on the assumption that all hospitals would operate training schools, which Heaven forbid! It is a *reductio ad absurdum* which gives us the clearest demonstration of the inherent fallacy in the present attempt to operate hospitals by the labor of student nurses. It is this policy which has flooded the market with nurses in excess of the present supply and which, unless checked, threatens to produce an over-supply of the gravest and most acute character. It seems quite evident that instead of a ratio of over five pupils per graduate in those hospitals which now operate training schools and a ratio of about one pupil per graduate for all hospitals, we must look, in a condition of stability, to a ratio of two or three graduates per pupil. This would mean the employment of some 200,000 graduate nurses in institutional work with

the student body kept at about its present level for some years to come.

TWO MAJOR CONCLUSIONS

I am well aware that these estimates are bold leaps in the dark. It is vitally essential, however, that we should face the facts involved; and it is only by an attempt, however crude, at quantitative visualization that our estimates can be criticized and revised. It appears to the writer that two major conclusions are amply justified by the data in hand:

The body of pupil nurses in the United States has been growing at so rapid a rate that it has already produced an oversupply of graduate nurses, an oversupply which will involve the gravest conditions of unemployment if it is permitted to continue. It is of urgent importance that further increase in the total number of nurses in training should for a time be avoided and that the needed expansion of hospital facilities should be accomplished by the employment of graduate nurses (and of ward maids).

While the total number of nurses available is already excessive, there is demand in every field for nurses of higher personal qualifications and sounder and more fundamental training. This is obvious in institutional and public health nursing—the fields in which alone marked future expansion is likely to take place; and it can scarcely be denied that the private duty nurse alone in a home with a desperately ill patient needs all the help that the soundest training can afford. A raising rather than a lowering of standards, both for admission and for instruction is therefore clearly indicated as the duty of the conscientious training school.

ORGANIZATION FOR BETTER SERVICE TO THE PATIENT

We have, so far, been looking at the problem chiefly from the viewpoint of the nurse. It is after all, however, the patient for whom hospitals and doctors and nurses exist. If there are enough nurses, or too many nurses, for the good of the profession, does the conclusion follow that all nursing needs of the community are adequately met? The answer of course must be in the negative. We have noted that 20,000 additional public health nurses are required to meet ideal standards and that hospital nurses must be substantially increased in numbers. Furthermore, in the private duty field the physicians replying to the questionnaire of the Grading Committee reported that of three patients needing a private duty special nurse, only two were able to employ one. It is not shortage in numbers of nurses, however, which underlies these deficiencies; but either the lack of the high type of nurse needed or, more often, inability to pay for the service required.

In the past we have attempted to meet this situation on a quantity basis by flooding the market with large numbers of nurses, sometimes of a quality inadequate to fit into a public health nursing organization or a well-ordered hospital. The result has been unemployed nurses on the one hand and unnursed patients on the other. Further lowering of standards can only aggravate unemployment with no real relief for the sick—since the difference between $6 a day for a graduate and $5 for a so-called "practical" nurse in no way solves the economic difficulties which are involved.

It is to organization that we must look for the real answer to this problem. The development of group nursing for the patient of moderate means in the hospital is one step. The development of hourly nursing service in the home is another. The organization of registries on a constructively cooperative basis is a third. By these means, and others which will be worked out in the future, we may hope to attain for every patient the amount and kind of nursing care which he really needs and for the nurse those four essentials of reasonable hours, adequate income, constructive leadership and opportunity for growth which Dr. Burgess has rightly formulated as vital to the very existence of your profession.

Such solutions are by no means simple or easy to apply. Hourly nursing, for example, can only be developed to full advantage when conducted by a well-organized public health nursing group which can furnish expert supervision and can take up the slack of the nurse's time by using her in other fields of visiting nursing as occasion offers. For the maximum of results, we must go still further and visualize a co-

ordination of all community resources both intra and extra-mural, under which nurses in the hospital and in the public health nursing organization and on the registry can be used where and when they are most needed.

In all this, it must be remembered that there are two distinct types of questions involved,—the problem of service and the problem of payment. We must first devise means for supplying to each patient the amount and kind of service (from simple domestic service, through the care of chronic or convalescent cases by a nursing attendant, to home nursing on the visiting nurse or hourly basis, and to continuous nursing of acute illness in the home or the hospital). We must develop machinery for facilitating payment for the service rendered through some form of insurance program, since many a family quite unable to meet the sudden financial emergencies of illness could bear the cost involved if it were distributed in time and over a whole social group. In this way there seems hope, as we are already realizing in the nursing furnished by the industrial insurance companies, of making self-supporting a considerable volume of nursing service once rendered on a philanthropic basis.

A CHALLENGE, AND A NEW VISION OF LOYALTY

These are problems which constitute a direct challenge to your profession; for they are, after all, primarily problems in nursing and can only be solved wisely with the active coöperation of leaders in the nursing field. I can foresee in the future that in every well-ordered community there will be a Joint Council on Community Nursing which will include representatives of hospitals and training schools, of official and voluntary public health nursing organizations, and of the registries which will make continuing studies of these problems and will strive to solve them through joint effort for the common good.

Already, your profession has made notable progress in the task of social organization. Nursing in hospitals and, above all, in public health nursing organizations, furnishes a model and an inspiration to other professions less socially minded. Can you not, in one or the other suitable community, go further and integrate the entire program in a community from the entrance of the pupil in a training school to the retirement of the nurse on an old-age pension, with a view to such professional conditions and such public relationships as will facilitate the highest type of service to the maximum number of patients on the soundest basis of payment?

It will require vision and it will require unselfishness to accomplish such things as these. Nurses are by tradition a loyal folk; but their loyalty, like that of all other human beings, is often too limited in its range of application. Loyalty to "my hospital" or "my association" is good; but loyalty should be broad enough to include not merely the whole profession but the whole community within its scope. Josiah Royce says that "In loyalty when loyalty is properly defined, is the fulfilment of the whole moral law"; but he adds in another place, "All lesser loyalties and all serving of imperfect or of evil causes, are but fragmentary forms of the service of the cause of universal loyalty." In the spirit of a wider loyalty and in the light of a deeper vision the nursing profession must find for itself the higher type of service which it is to render to the coming generations.

DISCUSSION

Meeting Community Nursing Needs from Hospital Angle, by Marian Rottman, Director, Nursing Service, Bellevue and Allied Hospitals, New York City. See *American Journal of Nursing*, July, 1928.

From the Community Angle—Sophie C. Nelson, Director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company.

The enumeration of our community needs in illness and health for which some nursing services are required seem simple, indeed. They might run somewhat as follows: Full-

time nursing care at home for people who can afford to have such care and for such illnesses as will require the full-time service of a nurse. Part-time service for some types of illness, especially those where scientific care on a full-time basis is not a requisite to the cure or retardation of disease. Part-time service for that group of people economically not prepared to pay for full-time service and where some other care is available. Nursing supervision in relation to home nursing care given by some member of the family especially in chronic cases or to convalescent care.

We need something more than enumeration, however, in order to understand our needs and the requisites for meeting them. We have available today prolific information in the form of absolute and computed data on morbidity and mortality, estimates of present and potential needs.

In spite of all this information, we have no accurate picture of disease and general ill health. We are still asking questions—how much, what kind, where—men or women—male or female—rich or poor—black, white or red—15 or 40. If we are to be useful as nurses in the field of prevention of disease and promotion of health, we further ask from whence, whither and why.

Full-time nursing service rendered through registries indicates that nursing care is reaching only a specific group in a community—the group who can pay for such service. It can never be said to be adequate as long as registries generally are organized as they now are to give nurses jobs. There is no relationship or coördination between registries conducted in different ways; that is, hospitals, business registries and the so-called official registries. We have no accurate picture of needs presented and just how they were met through this medium in any community.

First intending to reach the sick poor only, the scope of visiting nurse associations has been enlarged to try and meet the needs of anyone in a community desiring the part-time service of a nurse. Payment is made whenever possible on a "cost per visit" basis. The sins of visiting nurses have been of omission rather than commission, as they are largely inadequate through lack of quantity rather than through lack of understanding or desire.

The principle of visiting nurse service seems sound and the example leads one to optimistically hope it will be possible to organize all nurses on a basis of meeting the need and accommodating the nurses to it without too much difficulty.

Hourly service is probably best administered by visiting nurse associations who are already prepared for such organization. In some instances hourly nursing has been provided through the auspices of registries, this being an effort on the part of registries to take up the slack time of private duty nurses and provide for this need. This type of service is also provided by nurses who are, as it were, "on their own." The development of this community service is too new to make even a guess at its adequacy or potentialities.

In some communities visiting nurse associations are organized to provide nursing service for practically every type of disease. In many more communities a very limited service is given—always in a definite circumscribed area. The machinery is still not perfected to assume the obligations which the public puts upon it. In most instances service cannot be given at night, Sundays or holidays. Some associations are limited in scope; others in territory, and the possibilities are not nearly reached of what can and may be done through this medium.

Agencies have developed employing nurses in relation to the prevention of disease and health. Does this nursing group fill the community need? Never. Until recently there were sporadic efforts made by one agency or the other with very little relation to each other and no concerted action. Some service overlapped. Some service left off before others began. Even in a community which theoretically has numbers adequate to meet needs, there are many instances of gaps between the functions of agencies.

Again our inadequacy is largely due to lack of financial support and community understanding. Some times we have blind spots in our thinking which have lent an over-emphasis to one thing and an under-emphasis to another. Efforts in individual communities have been as different as communities are different.

The conclusion from my soliloquy would seem to be that but rarely do we adequately fill our community needs in nursing; in pri-

vate duty nursing largely because of our method of organization, in visiting nursing and in public health nursing in general through lack of numbers which in turn is largely due to lack of financial support.

Taking for granted that we have sufficient numbers of nurses and can allocate them as Dr. Winslow suggests, the real problem is more than a redistribution of nurses. It is getting a community appreciation of the situation. It is guaranteeing financial support to meet community nursing needs in excess of what the individual can meet.

We must realize that illness and health needs in a community are the actual factors which must be considered. The variable factor is nursing which must be changed to accommodate the situation, especially in illness which is always an emergency. The day of free lancing in nursing seems to be over. Some organized nursing effort must supersede the individual effort and it must be organized with one objective in mind—suiting the service to the need. Fire strikes when and where it will, and it must be met whether it is east or west, morning, noon or night. So it is with sickness. We must meet the needs of the service and make our arrangements accordingly.

Curiously enough, we have left almost entirely out of all our thinking an important assistance we may have, which is the opinion and judgment of those members of the community which we serve. Public health nurses have probably had the advantage over any group of nursing in this respect because for a long period of time they have had the support, the advice, the assistance and the interest of that group which, for a better name, are called "lay." These people represent much more definitely than we, the population we serve.

MEMORIAL BUILDING TO AMERICAN WOMEN IN THE WORLD WAR

Before a gathering of more than 500 representatives of official and social Washington, President Coolidge, who is also President of the American Red Cross, on May 31st laid the corner stone of the memorial building to commemorate the sacrifices and services of American women in the World War.

Chief Justice William H. Taft presided. The building was presented to the nation by Mabel T. Boardman, Secretary of the American Red Cross, through whose efforts it was made possible. The funds were raised by private subscription supplemented by an appropriation from Congress. Twenty-one women's organizations took part in the ceremony led by Clara D. Noyes, head of the Red Cross Nursing Service, Julia C. Stimson of the Army Nurse Corps, Beatrice Bowman of the Navy Nurse Corps, Lucy Minnigerode of the United States Public Health Service, Mrs. Mary Hickey of the Veterans' Bureau Nursing Service, Eleanor Gregg of the Indian Nursing Service and many others.

The Memorial was accepted on behalf of the nation by Secretary of War Dwight F. Davis. The older building commemorating the women of the Civil War together with this new Memorial and an office building soon to be erected to replace the temporary building now in use, will form three sides of an impressive quadrangle. Should the Delano Memorial be placed in its central court in the form of a reflecting pool and statue or a fountain set off by marble seats and shrubbery, the beauty and distinction of the quadrangle will be greatly enhanced.

THE DELANO MEMORIAL

It was voted to expend $5,000 of the Delano Memorial Fund to purchase one of the pillars of the new War Memorial Building to Women to be erected on the Red Cross grounds in Washington. The remainder of the fund is to remain at interest, pending the probability of obtaining a site between the present building and the new one, where a suitable memorial may be erected.

THE GRADING PROGRAM FROM THE MEDICAL VIEWPOINT *

By Nathan B. Van Etten, M.D.
Member of the Committee on Grading of Nursing Schools

THE patient, the physician and the nurse are the figures of a human triangle whose troubles are attracting the active interest of economists all over the world. The patient, the physician and the nurse are each fighting losing economic battles. The cost of sickness is so heavy for the patient that he is unable to properly pay his physician or to employ nursing commensurate with modern standards. While the patient fails to budget his sickness, the physician fails to budget his overhead and the nurse fails to budget her future. The patient charges his sickness deficit to fortuitous circumstance, the physician bequeaths his deficit to his heirs; and there is nothing left for the nurse but an old ladies home.

An announcement of a surplus usually excites an expectation of dividends, and while a surplus of labor usually suggests unemployment the evident fact is, that the surplus of nurses is crowded into cities and that cries of shortage still come from rural regions. A dividend is due—If your great organization can devise ways to distribute it you will greatly relieve an acute distress and unquestionably assist in a future solution. In spite of improving roads and increasingly rapid communication through motor service, physicians outside of large cities still complain that they have difficulty in securing competent nurses and that they are subjected to severe cross-examination by nurses reluctant to leave the allurements of the town.

The patient must be cared for, he is our first obligation, but he must be educated to budget his sickness and to understand that he seldom needs continuous expert care. Part-time nursing of one or two or four hours daily is often all that is needed in addition to directed observation and attention by some willing member of the family. Such a service might cost one or two or four dollars daily and be within the financial ability of the patient. While our present standards of living continue we cannot expect an educated specially trained person to work in the home for the fifty or sixty cents an hour wage of the uneducated scrub woman or laundress.

Last month I recommended to the Medical Society of the State of New York that:

> The minimum requirement for admission to a school of nursing be four years of high school, and that there should be included within this period by the State Department of Education an elective course preparatory to entering a nursing school to consist of instruction in what a nurse should know of the basic science of anatomy, physiology, biology, bacteriology and chemistry—the state thus taking over the responsibility for the preliminary education of the nurse. This should be followed by clinical instruction in the hospital with explanatory lectures and teaching in the art of nursing for two years for the degree of R.N. That an added year be given in courses for the degree of public health nurse or institutional nurse. Added periods of intensive training to qualify nurses for the operating room, or for obstetrics or eye and ear work or for psychiatry.

I do not consider this suggestion an ideal one that will be easily accepted by educators or by nurses, and I am quite willing to go much farther and more radically in the change in the scheme of the education of the nurse which is inevitable if the present intolerable situation is to be relieved, and the profession of nursing is to be advanced to a position it has never attained, distinguished by sound economic health.

* Excerpts from address given at a Joint Meeting, Biennial National Nursing Convention, Louisville, Ky., June 6, 1928.

NURSES, PATIENTS AND POCKETBOOKS*

By May Ayres Burgess, Ph.D.
Director, Committee on the Grading of Nursing Schools

TWO years ago I had the honor of appearing before you as the newly appointed director for the Committee on the Grading of Nursing Schools. Tonight I have come back to deliver into your hands this book** which contains the results of the study of supply and demand in nursing service upon which we have been working since that time.

It was not until April of this year that the members of the Grading Committee knew what was going to be in this book. Now that the facts are at hand we find ourselves unable to escape their implications. I think when you have read this book you will find yourselves beginning to think in terms of the following four main problems which will seem to you the inevitable responsibility of the nursing profession for the immediate future.

To reduce and improve the supply of nurses. Make a decisive and immediate reduction in the numbers of nursing students in the United States; and raise entrance requirements high enough so that only properly qualified women will be admitted to the profession.

To replace students with graduates. Put the major part of hospital bedside nursing in the hands of graduate nurses and take it out of the hands of student nurses.

To help hospitals meet costs of graduate service. Assist hospitals in securing funds for the employment of graduate nurses; and improve the quality of graduate nursing so that hospitals will desire to have it.

Get public support for nursing education. Place schools of nursing under the direction of nurse educators instead of hospital administrators; and awaken the public to the fact that if society wants good nursing it must pay the cost of educating nurses. Nursing education is a public and not a private responsibility.

It is from clearly substantiated facts and not from anyone's theory, that the four problems I have just cited have been drawn. What happens now will be determined not by the Grading Committee but by the members of its seven parent organizations. Of these seven parent organizations, the three nursing organizations represented at this convention are the most concerned.

EDUCATIONAL STANDARDS

It is a serious matter to discover that among those women who have been graduated within the past five years, just about one-sixth have never progressed beyond the first year of high school.† For the same group 10 per cent of the private duty, 22 per cent of the public health, and 22 per cent of the institutional have had at least one year of college. The college figures are encouraging, but the figures for one year of high school or less are genuinely serious. To-day there are free high schools in every town and village. Any young woman who does not go beyond the first year of high school, if she belongs to the modern generation, is at once a subject for scrutiny. Something is the matter. It may be that she will make a valuable nurse, but the chances are that she is stupid, or lazy, or worse.

One-sixth of all the recent graduates are in this undereducated and often underintelligent group. They are dangerous. Some go into private duty. They are unsafe people with whom to trust desperately ill patients, yet they go out into the field without supervision, and the patients have no means of knowing that they are not representative of the rank and file of nurses.

* Abstracts from address given before the Joint Meeting of the National Biennial Nursing Convention, Louisville, Ky., June 7, 1928.

** See *Nurses, Patients and Pocketbooks*, the official report of the Committee on Grading of Nursing Schools, reviewed on page 395 of this number.

† See *Nurses, Patients and Pocketbooks*, p. 251.

They are, therefore, not only dangerous to the patient, but they also bring the whole nursing profession into disrepute.

In the new book which I have brought to you to-night there is an entire chapter consisting of quotations from patients describing the nursing care which they have received. Some of these quotations will make you glow with pride. There are other quotations, however, some of which are rather dreadful. There will be nurses in this audience who will feel that the Grading Committee should never have permitted those quotations to appear in print, that such things cannot be typical. The Grading Committee believes that they are not typical of the care which the great body of the nursing profession renders to the sick, but they are unfortunately typical of experiences which some patients are having, because there are some nurses who should never have been admitted to the nursing profession and into whose hands these patients have been so unfortunate as to fall. It is because of the experiences which some patients have had with nurses of low caliber that the nursing profession often finds itself seriously misjudged.

There is serious unemployment in nursing. It is becoming increasingly apparent throughout all branches of the profession. As is natural wherever there is unemployment, the least skilful, poorest educated workers are the ones who are most apt to suffer. Naturally the more difficult their economic situation becomes, the more dangerous they themselves become. If they are unhappy and dissatisfied, they grow increasingly careless in their care of patients. They bring increasing disrepute to the profession. Somehow these undereducated women, of inadequate social and academic background, must be kept out of the profession. Fortunately there is no longer any need for them. We have ample evidence that instead of being a nursing shortage, there is to-day a nursing surplus.

NEED FOR SWIFT ACTION

In medicine in 1880 there were a little over 3,000 graduates. In 1920 there were barely 3,000 and in 1926 the number had again increased to about 4,000. Medical estimates indicate that the numbers of graduates each year through the next forty years will probably remain at just about 4,000. In nursing in 1880 there were 157 graduates for the entire country. In 1900 well over 3,000, in 1926 almost 18,000. The numbers of nursing graduates are rising with shocking rapidity. The rate is far beyond that of the increase in the general population.

These figures indicate why the Grading Committee is putting so much emphasis upon the need for swift action. If the nursing profession plans to put up the bars so that none but properly qualified students can enter, the more quickly it acts, the easier it will find its task. There are probably at the present time about 200,000 graduate nurses in this country. Approximately 128,000 of those nurses do not belong to the American Nurses' Association. The American Nurses' Association now enrolls about 35 per cent of all the graduate nurses in the United States. It is significant that the American Medical Association enrolls 73 per cent of all the graduate physicians.

NOT A SHORTAGE BUT A SURPLUS

Of the 353 registries who answered the question, Do you want more nurses?, 325 said "No." Only 28 said "Yes." Of these 28, 21 were connected with small hospitals.* Most of the registries were emphatic in stating that they could not keep employed the nurses who were already enrolled on their registries and would greatly regret any campaign to increase the numbers of nurses in their localities.

In March, 1926, in the 10 state study carried on by the Grading Committee among public health organizations, for every new appointment made to a public health nursing staff there were over five applicants. ** In the institutional

* See *Nurses, Patients and Pocketbooks*, p. 81.
** *Nurses, Patients and Pocketbooks*, p. 107.

field there are more applicants for that work than ever before. Everywhere graduating classes are larger than ever before.

It would seem clear then that since there is already serious over-production in the numbers of nurses, the time has come when entrance should be barred to the one-sixth of all these new-comers who are definitely below standard for entrance. Setting up high entrance requirements would at once serve to decrease the numbers of graduates, to safeguard the patients, to protect the reputation of the profession, and to make adjustments within the profession easier.

The first step would seem to be to reduce the numbers of schools and graduates and to raise their quality so that no school will exist unless it is doing a first class educational job, and no student will be graduated unless she is a genuinely high grade nurse.

It is easy, for example, to say "Let us abolish all small schools." However, owing to the distribution of students, if half the small schools in the country were put out of business, this drastic reduction would only cut down 22 per cent of all the students. If nurses are to be successful in limiting the numbers of graduates admitted to the profession, some of the large schools must also begin to reduce their numbers of students.

REPLACE STUDENTS WITH GRADUATES

Reduction in numbers of graduates can only come when many of the largest schools in the country consciously decrease the numbers of students whom they have in training, and consciously increase greatly the numbers of graduate nurses whom they employ on general floor duty. The second task which the nursing profession faces is to place the major part of hospital bedside nursing in the hands of graduate nurses, and to take it out of the hands of student nurses. It is going to be a new and very difficult thought for modern hospitals to grasp when they are told that it is no longer desirable to have them run schools of nursing. They have so long considered their educational activities as genuine contributions to social welfare that it is going to be hard for them to believe the time has come when they should stop attempting to educate nurses.

Superintendents of nurses give two reasons for wanting students rather than graduates. The first is that student nurses stay for three years and there is no labor turnover problem to worry about. The second reason is that superintendents of nurses find students more inspiring. This atmosphere of professional growth among graduate staff members is already well known in the public health field. If graduate nurses can be stimulating co-workers in public health, is it not reasonable to suppose that they might also be as stimulating when doing hospital nursing?

SCHOOLS UNDER EDUCATIONAL CONTROL WITH PUBLIC SUPPORT

It seems clear then that the numbers of nursing schools must be greatly reduced. There are 79 medical schools in this country. How many nursing schools should there be? Probably there should be more than 79, but almost surely there should not be 2,155, as there are now. It would seem that whatever nursing schools there are should be closely connected with the hospitals but should not be solely controlled by hospitals any more than medical schools are controlled by hospitals. There should be a coöperative relationship, with the hospital serving as the laboratory in which most of the students' learning takes place, but with the control of education definitely placed on the shoulders, not of hospital administrators, but of educators. The fourth great task which seems clearly to be indicated by these findings of the Grading Committee is gradually to shift the control of nursing education from hospital administrators to skilled educators, whose main task is not to administer nursing service but to administer nursing education. If society wants good nurses it must control their education; and—this is particularly important—it must pay the costs.

I should like to read two resolutions recently unanimously adopted by the members of the Grading Committee.

No hospital should be expected to bear the cost of nursing education out of funds collected for the care of the sick. The education of nurses is as much a public responsibility as is the education of physicians, public school teachers, librarians, and others planning to engage in professional public service, and the cost of such education should come, not out of the hospital budget but from private or public funds.

The fact that a hospital is faced with serious financial difficulties should have no bearing upon whether or not it will conduct a school of nursing. The need of a hospital for cheap labor should not be considered a legitimate argument for maintaining such a school. The decision as to whether or not a school of nursing should be conducted in cooperation with a given hospital should be based solely upon the kinds and amounts of educational experience which that hospital is prepared to offer.

The question which this book of the Grading Committee raises is not so much whether these things ought to be done, but rather *when* they ought to be done. In the light of the swift growth of the nursing profession can nurses afford to wait for the slow grinding of economic law? If the size of the profession is to double within the next seventeen years, and if, with the profession as large as it is now, there is already evidence of serious unemployment, is it safe to wait for these matters to work themselves through naturally, as they probably will; or should the profession take immediate steps to hasten their development?

The Grading Committee puts this book into your hands and says: "We have tried to furnish you with facts which you can use in the tremendously difficult undertaking which faces you now. We don't pretend to know what you are going to do, nor how you will do it; but we believe that you will map out your own campaign, and that you will proceed with swift precision, high courage, warm sympathy, and the wisdom of carefully considered experience, to carry your purpose through."

REPORT OF REGISTRATION AT THE N.O.P.H.N. BIENNIAL CONVENTION

Nurse and Associate Nurse Members	640
Non-Nurse Members	39
	679
Corporate and Associate Corporate Members represented	74

By States

Alabama	5	Montana	1
Arizona	1	Nebraska	4
Arkansas	7	New Hampshire	1
California	4	New Jersey	37
Colorado	3	New York	76
Connecticut	29	North Carolina	6
Delaware	3	North Dakota	1
District of Columbia	14	Ohio	49
Florida	3	Oklahoma	6
Georgia	9	Oregon	5
Illinois	37	Pennsylvania	36
Indiana	43	Rhode Island	12
Iowa	14	South Carolina	2
Kansas	8	Tennessee	19
Kentucky	58	Texas	8
Louisiana	7	Utah	1
Maine	5	Vermont	3
Maryland	4	Virginia	13
Massachusetts	25	Washington	1
Michigan	34	West Virginia	14
Minnesota	23	Wisconsin	20
Mississippi	1		
Missouri	23	Canada	4

ADULT EDUCATION *

By Charles H. Judd, Ph.D.
Head of the School of Education, University of Chicago

THERE is a striking parallelism between the problems which confront the members of the nursing profession and those which confront the members of the teaching profession. I was not conscious myself of the close family resemblance between our two professions until I read the recent reports prepared by the *Committee for the Study of Nursing Education* and the *Committee on the Grading of Nursing Schools*, when I began to realize that your profession, like the one which I represent, cannot fulfill its mission in the world unless it can find some way of extending its influence beyond the immediate routine ministrations which are its first and most obvious duties.

You are charged with the care of the sick. Teachers are charged with the responsibility of training children. But if care of the sick and training of children are to become entirely effective, they must be performed in such a way as to make the whole community intelligent.

The first elements in the situation are our own profession groups. We must ask how far the members of these groups are equipped to become agents of society for the discharge of a double duty. I am sure that with nurses as with teachers there are so many grades of equipment that one must always recognize, in speaking of the profession, its composite and unstandardized character.

There are certain very fortunate circumstances in present-day conditions. There are in the larger centers of population enough applicants for admission to our professions so that we can begin to raise the standards of admission and the requirements of graduation from training schools.

There are serious impediments, however, to the establishment and maintenance of standards. There are a great many persons entering our professions who are only transient members. There are, so far as I know, no professions other than those of teaching and nursing which are so largely disturbed by early withdrawals. There is a demand for continuity and stability in most of the professions which cannot face the shock of withdrawals which the teaching profession and the nursing profession experience every year.

While we are enumerating our handicaps, we may as well face frankly the further fact that we do not agree among ourselves as to the proper course of training which we should administer to novitiates. I gather from what I read that you have the added difficulty that your training schools extract an amount of service from nurses in training which no teacher-training institution would venture to demand.

The consequences of this widespread demand for teachers and nurses are evident. There will be—as indeed there is—very general tolerance for mediocrity, and very general acceptance in an emergency or in what seems to be an emergency of only partially qualified persons.

In situations such as those in which our professions find themselves, there must be provided substitutes for individual efficiency. I hasten to qualify this statement. There is, of course, no possible justification for relaxation of effort in removing so far as possible any deficiencies which exist in the training of individuals. The profession as a whole must come to the aid of the individual with devices which

* Excerpts from address given at the opening meeting of the National Biennial Nursing Convention, Louisville, Ky., June 4, 1928. For full address see *American Journal of Nursing*, July, 1928.

will make that individual more effective than he or she would be if operating in a purely personal way.

We have come to recognize in teaching the absolute necessity of bringing experienced teachers back into training institutions after they have been out in the field. To-day all progressive teachers come back to normal schools and colleges for what we call continuation training or training in service. The day has passed in education when a teacher can depend on her initial preparation to carry her through life.

I venture to advocate that the nursing profession give up the doctrine that a nurse is forever competent because at one time somebody put on her the stamp of approval as a graduate of some more or less adequately equipped training school. I shall not attempt to say that every nurse should be obliged to come into a training school for one month in the year in order to make sure that she has not contracted intellectual coma, but I am willing to assert that some continuation training in service for nurses would promote the well-being of the nation.

From the point of view of the training school itself, I can think of nothing that is more likely to keep it in touch with practical needs than this periodical homecoming of its own graduates and the graduates of other schools.

Many of you go into homes where there is a high emotional tension growing out of the conditions which the family faces. Would it not be well somewhere along the line of the training course given to nurses to introduce some scientific information about the nature of emotional tensions? I am not making a plea for the teaching of a formal course in psychology. I am arguing for the presentation of practical simple information about what happens in a human nervous system and in a human body in emotion. I know of no greater service than to have a well-trained group of nurses prepared to teach people how to behave in those emergencies in which excitement is a major factor. If nurses did nothing more for the families of patients than to teach them how to behave under tension, the education of adults would have made great progress in this country.

Another concrete item which is suggested to me out of my experience with schools is that most families need a firm guiding intelligence to give them help in selecting a diet of suitable materials, adjusted to the family purse. Many a family diet has been reformed through the example of good school luncheons. I am not making a plea here merely for a course in dietetics. I am advocating a course in economics. Nurses come into contact with many homes where financial considerations are important.

A third type of intelligence which I believe a nurse should leave behind is a series of references to reliable reading matter dealing with health and personal self-management. People want to know where to get information on such matters. Witness the eagerness with which syndicated matter in the newspapers is read by the public. The well-trained nurse can do much while she is in a home by way of direct teaching of methods of hygienic living, but the lasting influence of her teaching will be greatly increased if she guides the reading which will go on after her departure.

Nurses and teachers have made what seems to me to be a fundamental economic mistake. They have adopted as far as they have been able to do so a uniform scale of salaries. It is, of course, legitimate that our professional groups should unite in securing for our members compensations which make it possible to live, but when we insist that the partially trained and the well trained shall have the same returns for their labors, we make the mistake of withdrawing one of the strongest incentives to improvement. I have no recommendations to make except to point out the fact that a profession which attempts to equalize compensations is more likely to be dominated by the majority than by its superior members.

MENTAL HYGIENE IN A GENERALIZED NURSING SERVICE

By Grace E. Allen
Supervisor, East Harlem Nursing and Health Service, New York City

Editor's Note: We quote only in part from Miss Allen's interesting paper read before the Joint Meeting at the National Biennial Nursing Convention, Louisville, Ky., June 6, 1928. Excerpts from papers read at the same meeting by Drs. William L. Russell, Ralph P. Truitt, Frank J. O'Brien, appear in the *American Journal of Nursing*, July, 1928.

OF all the reasons for including mental hygiene in public health nursing, two stand out:

First, from the standpoint of the staff worker, mental hygiene is a tool for health teaching. Any worker in the social field, whether a public health nurse, a visiting teacher, a minister, a physician or a social worker can do better teaching if he is aware of the kind of person with whom he is dealing. Mental hygiene gives a better understanding of the effect of environment upon personality.

Second, from the standpoint of the mental hygiene movement, the staff worker is an instrument.

If every public health worker could supplement her hospital training and field experience by fourteen months at the Smith College School of Social Work it would be ideal. But few of us can do this. As a matter of fact, the average nurse graduates from her three year hospital course almost unprepared for public health. She learns public health by doing public health nursing, preceded or accompanied by courses in the theory of public health nursing.

If psychiatric social workers could be attached in sufficient numbers to the public health nursing organizations to care for the problems that arise in those organizations, then the problem of providing mental hygiene would be relatively easy. The public health nurse, under supervision, could find the problem in her intimate family contacts and the trained workers attached to the organizations could refer the patient to a mental hygiene clinic and do the follow up work.

We know that public health nurses are not expert workers in this branch of public health, but we think that they are at present potential assets, for these reasons:

They see the patient in his family setting, generally before any other worker has had an entree to the home. The public health nurse—the good public health nurse—knows the personalities that make up the family in which she works. Can she not be trained, along with her other field experience and techniques, to recognize signs of mental maladjustment and of behavior difficulty in children, sufficiently early to permit hope of improvement?

Another reason for using the public health nurse in a mental hygiene program is that mental hygiene is a tool for good health teaching. Why should the public health nurse be denied access to it? If the hospitals have not helped the nurse to understand mental hygiene; if the courses in public health theory have failed to prepare her to meet adequately this phase of her public health work; if organizations pay for her services and accept them without trying to make her a more efficient worker in public health—this does not mean that the deficiency should not be remedied. To say that the nurse cannot do mental hygiene work is to clamp a "no" down on a field of a nurse's usefulness, without adequate data for the conclusion.

The East Harlem Nursing and Health Service, after an experiment which is still continuing, thinks that with adequate guidance from a psychiatrist and under proper supervision, staff workers can carry mental hygiene as an integral part of a health service.

The nurse shall find the problem in her daily work.

The nurse shall with the guidance of the mental hygiene supervisor, first, write a social history of the problem; second, arrange for physical and psychological examination; third, the nurse shall carry out the recommendations made by the psychiatrist, under the close supervision of the psychiatrist and the mental hygiene supervisor.

The public health nurse is supervised and helped. The psychiatrist discusses each problem with her. The mental hygiene supervisor arranges details of follow up work. But the staff worker carries out the recommendations for the patient whom she has referred to the psychiatrist.

Certainly no one would advocate turning a public health nurse loose to organize and run unaided her own mental hygiene clinic any more than she would be expected to run a tuberculosis clinic without a physician to head it up. There must be a set-up; a psychiatrist, a psychologist, and a mental hygiene supervisor. A mental hygiene program would never fit into the work of an organization doing a generalized piece of work unless the supervisor, who is a liaison officer between the field worker and the psychiatrist were fully aware of the staff worker's case load. That would be poor mental hygiene in itself. The mental hygiene supervisor must know what the staff worker must do each day in clinic routine and in acute work, just as the nutrition or tuberculosis supervisor must know the pressure of acute illness. This question of acute work is a serious problem in a public health nursing organization. No one can evade it. When pneumonia cases are reported in bunches, a staff worker postpones nutrition work, tuberculosis work, and mental hygiene work. While the burden of acute illness does hamper the mental hygiene field work, still it is not a serious enough drawback to necessitate giving up the entire mental hygiene service.

Future developments, if public health nurses are to do efficient work in a nursing organization's mental hygiene clinic are:

The inclusion in hospital training of courses in mental hygiene.

The addition to college courses in public health of a major in mental hygiene.

The provision of practical experience in mental hygiene field work.

DR. HIDEYO NOGUCHI

To the lengthening roll of heroes of science who have sacrificed their lives in the cause of human health and welfare, has been added Dr. Hideyo Noguchi. This noted Japanese scientist died of yellow fever in Accra, West Africa, May 21, 1928. It is unfortunate for both science and civilization that there is no way to dramatize the story of Noguchi and his great achievements. He has been a Commanding General among the forces fighting preventable diseases. Yellow fever, syphilis, trachoma, are among those toward whose conquests he made notable contributions. Improvements in the preparation and use of vaccines for protection against small pox, and of antivenins to counteract the results of poisonous snake bites, are among other types of life-saving researches credited to Dr. Noguchi.

In one way or another every member organization in the National Health Council is indebted to this great scholar, leader, and friend of mankind of whom it may be said in Stevenson's words—"Gladly he lived, and gladly died, and he laid him down with a will." Japan and the United States will feel his loss intimately as of a member of the family, but Dr. Noguchi belonged to the world and wherever scientific progress is being made the news of his death will be received with a sense of great loss.—*William F. Snow, M.D., President of the National Health Council.*

Baskets of beautiful flowers, fresh daily, were the gift of the War Mothers of Kentucky to the Biennial Convention. No other single expression of welcome was more touching nor more appreciated by the nurses.

CONVENTION REPORTS

PARTIAL REPORT OF THE PRESIDENT, MRS. ANNE L. HANSEN *

WE who were two years ago instructed with the responsibility of guidance of the N.O.P.H.N. have come to render an account of our stewardship at this biennial stock-taking. Year by year the N.O.P.H.N. has extended its activities and growth and in like proportion its responsibilities have increased.

To-day public health organizations are engaging in self-analysis as never before. A good deal of study is being given to the proper distribution of nursing service, cost and time studies and the question of county relationships. Boards of directors are looking into the question of staff education and studying their own responsibilities as evidenced by institutes and the preparation of an N.O.P.H.N. Manual for board members' use. There has been developed a self-consciousness in public health nursing which is resulting in self-study.

Two years ago Miss Fox's presidential address left us tingling with enthusiasm; she gave us courage for daily toil and also warned us against "becoming impervious to new truths." If in the last two years the N.O.P.H.N. has in some measure been able to meet this ideal it has been because of the inspiration she and other members of the Board of Directors have given. They have executed each duty in an endeavor to bring advancement, contentment and peace to the membership.

As we started on the two years' trip one of the outstanding objectives was the development of our lay membership. Since the last Biennial there has been a closer and still closer weaving together of the lay and professional membership. The first step to this end was the appointment of a Lay Committee with Mrs. Whitman Cross of Washington as Chairman. The Committee has done splendid work and was proud to report at its last meeting that it had 100 per cent attendance. In the light of the remarkable achievements of the board members' group we of the professional group are beginning to realize that we can no longer throw facts at our lay members like snow balls. We are two inseparable parts of a living whole and must work on our programs together.

Much attention has been given during the last two years to the nurses in industry. There has been serious consideration as to how the N.O.P.H.N. can strengthen the position of the industrial nurse. It has been felt that the industrial nurses are in a fairly unknown field and now a systematic study is under way to find out where the nurses are and what they are doing.

The Branch Development and Revisions Committee with Gertrude Bowling, Chairman, has had many meetings covering hours of strenuous work. The Committee and the Executive Board are more than anxious about the condition of the State Branches. These children of the N.O.P.H.N. should be its very strongest support and yet many of them are suffering from malnutrition to a most serious extent. It is hoped that the members will have suggestions to offer after this meeting which will result in new life and strength to the N.O.P.H.N. branches.

A most important work of the N.O.P.H.N. is in relation to educational work for public health nursing. Under the tireless leadership of Katharine Tucker the Education Committee has been faithfully guiding our educational policies. At frequent intervals organizations in all parts of the country have applied to the Education Committee for approval of educational plans made locally. It is a wholesome

* N.O.P.H.N. Business Session, Biennial Convention, Louisville, Ky., June 4, 1928.

thing that the Education Committee has been able to make a careful study and to occasionally withhold approval of plans where it has been shown it would be unsound and unwise to go ahead. The Committee has been collecting facts about undergraduate affiliations and staff education, at the same time continuing its interest in the postgraduate courses. Some of you may not be especially interested at present in undergraduate affiliations but it is wise to listen carefully to what the Committee has to offer because one never knows what the future holds. All will admit that staff education is of supreme importance and concerns all members whether on a staff or working alone. It is so easy to get into a rut and it has been said that the only difference between a grave and a rut is that one is longer than the other.

One of the most important committees is that of finance. During the last two years Mrs. John A. Haskell of St. Louis has been Chairman of the N.O.P.H.N. Finance Committee and under her leadership the nine members have done heroic work. Every item of expense of the Organization has been carefully considered and investigated by the Finance Committee and finally a yearly budget has been prepared to be submitted to the Executive Board. The N.O.P.H.N. today is in a healthy financial condition and there is no reason why it should not grow in strength from year to year especially if the nursing organizations throughout the country will continue to give full coöperation in the percentage plan.

Every public health nurse is concerned with the matter of records and no committee of the N.O.P.H.N. has labored with more devotion than the Records' Committee under Mrs. Mabel DeBonneval. Each member of the Committee will think that her time has been well spent if the N.O.P.H.N. members begin to give more serious study and consideration to the records and in consequence make the day's work of infinitely more value.

You will be interested in the report of the Joint Vocational Service where Grace Anderson, Alta Dines, Mary Gardner and Elizabeth Stringer, have done wonderful service coöperating with the public health nurse secretary, Anna Tittman.*

The work of the Grading Committee has done much to bring about a sense of unity in nursing groups. It has made us feel that some way or other we must shed intolerance and grow out of selfishness. A short time ago the following lines came to my attention. "The tragedy of the age is not that men are poor, all know something of poverty—not that men are wicked, who is good?—not that men are ignorant—nay—but that men know so little of men." As a group we in public health have held aloof, perhaps not always knowingly but because we were so busy with a new piece of work. This now is stabilized so there is no longer that excuse for lack of interest in the whole of the great profession of nursing. It is vitally important that we members of the N.O.P.H.N. become more interested in the work of the schools of nursing where the fundamental principles and basic training in our profession are given.

This meeting is another milestone in public health nursing history. May we never fail to remember that membership in the N.O.P.H.N. means allegiance to the cause of public health nursing in the whole country and not with interest centered in New York, Pennsylvania, Kentucky, California, or whichever state claims our citizenship. As members of a National Organization we must give loyal interest and support to public health nursing efforts in the remotest corner of the most rural state.

* See page 346.

The 1930 Biennial Convention will be held in Milwaukee, Wisconsin.

EXCERPTS FROM REPORT OF THE GENERAL DIRECTOR, JANE C. ALLEN

The present administration of the N.O.P.H.N. started out two years ago to effect, if possible, a more democratic functioning of our New York headquarters office in relation to the nation-wide membership, both individual and corporate.

Thus in the designation of the personnel of the various committees, we adopted the plan of appointing a large committee, which would be fairly representative of the different sections of the country, and a small executive section of those near the New York office to meet and transact committee business. Well in advance of the meeting of each committee's executive section, letters have been sent out to the entire committee, advising as to the topics to be discussed, and asking for suggestions and opinions. After each meeting full minutes have been sent to the entire committee.

We have tried, as much as possible, to avoid duplication of personnel and to distribute individual responsibility for committee work. It seems unfair to ask the same people because they happen to be located near New York to serve on several N.O.P.H.N. committees. On the other hand, a certain amount of this duplication is quite unavoidable because of the fact that the N.O.P.H.N. budget for committee travel is definitely limited.

Following out the policy adopted in 1925 we have endeavored to have our executive staff give a generalized service. Instead of assigning staff members to specific and special activities when making field advisory visits, we have asked each worker to be responsible for giving such general service as seemed necessary. This has been in the nature of an experiment, and has not yet been made a permanent policy. A definite effort has also been made to have the N.O.P.H.N. represented each year at as many of the state and annual meetings as possible and state associations in the same part of the country have been urged to make the dates for their meetings consecutive in order that the national representative might attend a series of meetings on the one trip and thus reduce the expense to each association.

Another definite policy has been to get across to our individual and corporate members the interpretation of the N.O.P.H.N.'s place in public health nursing as that of service to the profession as a whole. We have suggested whenever possible that a national service to public health nursing consists of ascertaining on the one hand current problems which seem most insistent throughout the country and on the other, the way in which the different public health nursing organizations seem to be meeting these needs. Thus the N.O.P.H.N. office makes a point of assembling authoritative information as to current practice and of giving it back upon request through magazine, correspondence or personal interview.

CO-OPERATION WITH OTHER NATIONAL HEALTH AGENCIES

Your National Organization has been represented throughout the past two-year period at the monthly meetings of the National Social Work Council. The National Tuberculosis Association and the N.O.P.H.N. have had many and frequent contacts. The American Social Hygiene Association and the N.O.P.H.N. have recently organized a small joint committee to consider a possible coöperative activity.

In the fall of 1926, the General Federation of Women's Clubs asked us to appoint a representative to act as consultant to the National Chairman of their Public Health Section. We appointed Miss Cecilia Evans of Wisconsin to represent the N.O.P.H.N. In collaboration with our staff, she assisted the Public Health Section of the General Federation in drawing up a "suggested outline for use of women's clubs in the state and local nursing services" which was published in December, 1927, in THE PUBLIC HEALTH

NURSE. The N.O.P.H.N. also, upon request, prepared a "Suggested Program for the Tuberculosis Committee of the Federation of Women's Clubs," published in the March, 1927, magazine.

Another helpful relationship in the headquarters office is that between the American Public Health Association, especially its Committee on Administrative Practice, and our Records Committee, and more recently, our Advisory Committee on Field Studies.

Early in 1927, the National Society for the Prevention of Blindness approached us in the matter of forming a small joint committee in order that both national groups might work in harmony in relation to public health nursing as it touches the field of eye conservation in schools and homes.

COMMITTEES

Our N.O.P.H.N. committees have been very active during the two years.

The Publications Committee, Elizabeth Fox, chairman, held three meetings. The Finance Committee, Mrs. John Haskell, chairman, met twice. The Education Committee, Katharine Tucker, chairman, met five times. The Branch Development and Revisions Committee, Gertrude Bowling, chairman, has had three meetings, the Eligibility Committee, Gertrude Hodgman, chairman, three meetings, and the Records Committee, Mrs. Mabel de Bonneval, chairman, seventeen meetings.

At our 1926 meeting in Atlantic City a formal request was made by the lay members for a section in the N.O.P.H.N. Out of this came the appointment of a committee to Study the Advisability of a Lay Section. This committee is made up of six lay N.O.P.H.N. members, with Mrs. Whitman Cross as chairman. It has held four meetings and has been conducting during the two years a careful study of lay interest in public health nursing in the various states.*

In 1927 another suggestion came from one of our lay members that the N.O.P.H.N. prepare a Board Members' Manual and a committee was appointed of five lay members and one nurse member. This committee, Mrs. G. Brown Miller, chairman, has held five meetings, and will present its report to us later on in the Convention.**

A new committee appointed during 1927 is the Service Evaluation Committee, Dr. Haven Emerson, chairman, which replaces the old committee to consider questions on the Report of the Committee to Study Visiting Nursing, which continued on after the completion of the 1926 study. The committee is now working out plans for a follow-up study of time and cost in order to bring the original report on visiting nursing up to date.

Early this year, a new Advisory Committee on Field Studies was appointed. Requests for N.O.P.H.N. studies of local nursing services have been increasing and it has seemed desirable to have a small committee carry advisory responsibility in this connection. The personnel of this new committee is also that of the new Subcommittee on Nursing of the American Public Health Association's Committee on Administrative Practice. Dr. Walker of the American Public Health Association has acted as consultant to the committee.

During 1927 our attention was drawn again and again to the need for a definition of the responsibilities of public health nurses working in county health units. This was one of the questions which our Board of Directors laid before our Advisory Council at a joint meeting last January, following which a committee was appointed which will make a special study of this question.

At the request of the National League of Nursing Education, we have designated two of our nurse and one of our lay members to represent us on a new joint committee of the three national nursing organizations known as the Committee to Study the Distribution of Nursing Services. At the request of the joint boards at their January, 1928, meeting, we have also appointed representatives on a joint Committee to Study Possible Lay

* See report of this committee, page 358.
** See page 349.

Association with Nursing Organizations. A third new joint committee is a committee of the American Nurses' Association and the N.O.P.H.N. to study the proposal that we have a triennial instead of a biennial convention.

FIELD SERVICE

During the past two years, a staff representative has visited every one of the major sections of the country.

Early in 1927 the General Director made a two-months' trip to the West and far West, stopping in four states and addressing groups of nurses and lay board members aggregating a total of 3,000 people.

The staff has also been represented at 18 annual state meetings and our extension secretary has visited 11 states in the interest of the percentage plan.

An important N.O.P.H.N. service to the field is that of making, upon request, local studies of public health nursing services. During the past two years such studies have been made in six communities. These have been paid for by the local organizations requesting the studies.

The records advisory service under our statistician has been developing slowly but steadily. A number of local public health nursing agencies in the vicinity of New York have been visited for purposes of studying their record systems and rendering advice as requested.

BUSINESS DEPARTMENT

The present administration fell heir to a sound financial policy which had been worked out by the previous Board. The separation of membership and subscription fees which went into effect January 1, 1927, has proved a wise move and has helped to bring the N.O.P.H.N. to a sound financial condition for the first time in its history. The percentage plan of support by our corporate members has also been largely responsible for this, and as it continues to grow and more organizations take part in it, we should be in a position to render a wider service to public health nursing.

The original three year period for our financial study, which is made possible by a special fund for that purpose, is now ended and we are happy to announce has been extended for an additional two years. We confidently hope that by that time the percentage plan will be firmly established and functioning smoothly.

Early in 1927 we paid the last dollar of the debt that had been weighing upon us for almost three years. Upon recommendation of our Finance Committee, we are maintaining a reserve fund, not to exceed $5,000, which we hope will preclude the possibility of again incurring a debt.*

MAGAZINE

Our magazine has benefited also from the improved financial condition of the N.O.P.H.N. generally. The $11,000 annual deficit in the budget for the magazine which had been more or less prevalent for many years, has with the straight subscription policy, and the new management of the advertising department, been reduced to $5,000.

Our subscribers should know that even the higher subscription rate does not cover the cost of the magazine and that each subscription continues to represent a definite return to each member subscriber on the $3.00 membership fee.

STATISTICAL STUDIES

The statistical department renders a direct service in the assembling of information about the conduct of public health nursing throughout the United States. During the past two years, the following special studies have been made:

Nursing fees.
Resources in state divisions or bureaus of nursing.
Preschool nursing.
Delivery service.
Communicable disease nursing.
Orthopedic nursing.
Staff education.

* For the complete financial statement for 1927, see THE PUBLIC HEALTH NURSE for March, 1928, page 146.

In addition, we are making each year follow-up studies of salaries and of students in public health nursing courses.

By a special arrangement, the Grading Committee made for the N.O.P.H.N. Education Committee a study of undergraduate affiliations in public health nursing. The report of this study as well as of the staff education study will be published later in the magazine.

SECTIONS

Considerable time has been spent by the staff in an effort to strengthen our Tuberculosis, School, and Industrial Nursing sections. An interim program for each has been prepared and assistance given the section chairman in planning ways and means for carrying it out.

BRANCHES

The N.O.P.H.N. now has fifteen branches, the New York State Organization for Public Health Nursing being the most recent addition. The Branch Development and Revisions Committee plans to draw up a minimum yearly program for each Branch in the hope that it will prove helpful in maintaining a wholesome activity for the good of public health nursing under Branch leadership.

Our state branches mean a great deal to the N.O.P.H.N. They should be sources of strength and growth for the National Organization, assisting us in interpreting to nurse and lay members and to local public health nursing agencies the meaning of a national service such as the N.O.P.H.N. tries to render. The N.O.P.H.N. wants its branches to grow stronger and become more effective for it is realized that their strength and effectiveness will inevitably mean added power to the whole profession. We believe that the best basis for such development consists in a realization of the possibilities which lie in the participation of lay or non-nurse board members in branch activities. We hope our fifteen branches will concentrate during the coming Biennial period upon building up an active lay membership.

Strong state branches, active N.O.P.H.N. sections, effective and frequent contacts between the N.O.P.H.N. executive staff and local public health nursing groups, as democratic a functioning of N.O.P.H.N. in relation to the whole country as is possible, an economical but effective administration of N.O.P.H.N. business affairs, and a constant effort to maintain the best of coöperation with other agencies in the field of public health—these are some of the modest aims of your General Director and her assistants as they look forward to the next two years.

NEWLY ELECTED OFFICERS AND DIRECTORS OF THE N.O.P.H.N.

President—Mrs. Anne L. Hansen, R.N., Buffalo, N. Y.

First Vice-President—Winifred Rand, R.N., Detroit, Mich.

Second Vice-President—Sophie C. Nelson, R.N., Boston, Mass.

Directors, Nurse Members—Gertrude Bowling, R.N., Washington, D. C.
Ann Dickie Boyd, R.N., Denver, Colo.
Alta E. Dines, R.N., New York, N. Y.
Grace Ross, R.N., Detroit, Mich.

Directors, Sustaining Members—Mrs. Chester C. Bolton, Cleveland, Ohio.
Mrs. John A. Haskell, St. Louis, Mo.
Dr. Ira V. Hiscock, New Haven, Conn.
Anna M. L. Huber, York, Pa.
Mrs. C.-E. A. Winslow, New Haven, Conn.

Nominating Committee for 1930—Mrs. T. Kraker Guthrie, R.N., New York, N. Y.
Naomi Deutsch, R.N., San Francisco, Calif.
I. Malinde Havey, R.N., Washington, D. C.

REPORT OF THE JOINT VOCATIONAL SERVICE—ANNA L. TITTMAN

At the last biennial, members of N.O.P.H.N. received our president's report to the effect that the Executive Committee had reluctantly voted the discontinuance of the vocational service on January 1, 1927, and had approved further negotiations with representatives of the American Association of Social Workers for establishing an amalgamation of the vocational activities of the two organizations as a separate entity. To-day it is my happy privilege to point out to you that the vocational service has gone on uninterrupted and without reduction in accomplishment. It gives promise of continued growth and permanency.

On January 1, 1927, Joint Vocational Service for Social Workers and Public Health Nursing opened its doors. The Joint Vocational Service functions with the authority of the N.O.P.H.N. and the A.A.S.W. under a charter of incorporation. The Board of Directors consists of six representatives from each of the parent organizations and one representative from each of the following professional agencies:

American Red Cross
American Public Health Association
American Association for Organizing Family Social Work
Child Welfare League of America
National Committee on Mental Hygiene
National Tuberculosis Association
American Association of Hospital Social Workers
American Association of Psychiatric Social Workers
National Catholic Welfare Conference
The National Conference on Jewish Social Service

The maximum membership is set at 35. There are now 24 members on the Board with 4 more to be appointed shortly. The Executive Committee consists of nine members and there is a Finance Committee organized in 1928 and there are two Advisory Committees—one for each professional interest. They take an active part in policy formation. The Advisory Committees render invaluable aid in suggesting plans for candidates whose unusual abilities or shortcomings require special handling. They constitute case conferences at which the complete record of selected candidates are presented. Since many of the failures to adjust seem to have an emotional problem, the Committee on Public Health Nursing is particularly fortunate in having a psychiatric social worker as a member.

Contrary to some predictions the fee basis for vocational service has caused no known opposition. On the other hand, a great many candidates and others have expressed themselves as favoring the procedure. We especially appreciate the occasional voluntary contributions from candidates who were registered in the service but may have become otherwise placed or who have used the service only for having their professional histories compiled and kept up to date. The latter is a service J. V. S. is happy to render and in addition will send the history without charge to prospective employers named by the candidate.

We are making a special feature this year of bringing together candidates for summer work and organizations needing workers for summer projects as camps and vacation homes or summer relief. This feature has forced up our May number of placements in public health nursing to the largest number in any one month since the inception of the service in 1922, 37 placements and 4 others materially assisted.

In 1927 J.V.S. handled 1669 new positions of which 611 were in the public health nursing field in comparison with 629 handled in 1926. This phase of the service has practically doubled since 1923.

An analysis of positions filled in relation to number listed from a given locality indicates a genuinely national service. We filled 60 per cent of the public health nursing positions reported from the far west and foreign field, 58 per cent of New York City, while the other sections of the country ran between 32 per cent and 42 per cent.

The members of the N.O.P.H.N. voted at the business meeting on June 4, 1928, in Louisville, Ky., to take out articles of incorporation. The new charter and revised by-laws will be sent to all members of the N.O.P.H.N. as soon as possible.

N.O.P.H.N. SCHOOL NURSING SECTION

The School Nursing Section of the N.O.P.H.N. held its biennial meeting during the Biennial Convention, Louisville, Kentucky, June 5, 1928, and adopted the following suggestions for an Interim Program:

To promote a better understanding of school nursing among members of school boards and school committees, superintendents of schools, principals of normal, secondary and elementary schools, through efforts of our state regional advisers, by means of conferences, and by securing qualified speakers to talk on school nursing; such talks to cover objectives, scope of work and methods as well as desirable qualifications for school nurses.

The following officers for the section were elected:

Chairman—Ann Dickie Boyd, Denver, Colorado.
Vice-Chairman—Mary E. Chayer, Des Moines, Iowa.
Directors, four years—B. B. Randle, Olean, N. Y.
Elma Rood, Nashville, Tenn.
two years—Anna L. Stanley, Providence, R. I.
Lay Director, four years—Dr. Edna Bailey, Berkeley, Calif.

Flora Burghdorf, as nurse member, and Grace Abbott, as non-nurse member, continue until 1930.

N.O.P.H.N. INDUSTRIAL NURSES SECTION

A meeting of the N.O.P.H.N. Industrial Nurses Section was held in Louisville, Kentucky, June 7, 1928, with Marie Brockman, chairman, presiding.

Ruth Waterbury reported that the plans for the N.O.P.H.N. census of industrial nurses were well under way and that a report would probably be made at the next Biennial Convention. Approximately 165 nurses were present at this meeting.

The following suggestions for a program to be carried on during the next two years were presented:

To stimulate industrial nurses in various states to form industrial sections where numbers make this advisable.

To hold an interim meeting of the section in coöperation with some professional group such as the Industrial Hygiene Section of the American Public Health Association.

The following officers and directors were elected:

Chairman—Ruth Waterbury, Metropolitan Life Insurance Co., New York City.
Vice-Chairman-Secretary—Wilhelmina A. Carver, American Pulley Company, Philadelphia. Pa.
Nurse Directors—Mrs. Marion Brockway, New York City.
Marie Brockman, St. Louis, Mo.
Marietta B. Squire, New York City.
Mrs. Edith Hill, Cambridge, Mass.
Nurse representative from California, to be named later.
Lay Directors—Mrs. Austin Levy, Harrisville, R. I.
Dr. Cassius B. Watson, New York City.
Advisers—Safety representative to be named later.
Industrial relations representative to be named later.

N.O.P.H.N. TUBERCULOSIS SECTION

The business meeting of the N.O.P.H.N. Tuberculosis Section was held in Louisville, Ky., June 6, 1928, the chairman, Mary Carter Nelson, presiding. Sixteen responded to the roll call of the state chairmen.

The chairman read the summarized reports of activities from 26 states in connection with the interim program. She stated that unless suggestions for a change in the program be received at headquarters by July the same program will be continued until the next biennial period.

The following officers were elected:

Chairman: Mary Carter Nelson, New York.

Nurse Directors: Sidney McGuire, Los Angeles, California; Virginia Martin, Lexington, Kentucky; Virginia Chetwood, Hackensack, New Jersey; Margaret Hughes, Chicago, Illinois.

Lay Directors: Mrs. W. K. Schoepf, Ohio; Dr. Philip P. Jacobs, New York; Mrs. Bethesda Beals Buchanan, Seattle, Washington.

REPORT OF BOARD AND COMMITTEE MEMBERS SECTION

The new section was enthusiastically received and met at luncheon to adopt rules and elect officers.*

The subsequent meetings of the Section were attended by from fifty to eighty board members, the highest registration being eighty-two. Two of the formal papers presented appear in this number of the magazine** and a report of the discussions will be printed in August in the department of the magazine known as the Board Members' Forum.

The report of the Board Members Manual Committee appears opposite.

The value of the Board and Committee Members meetings cannot be estimated by the official report and printing of papers and discussions. Those present really met and discussed every moment from Monday until Thursday. We regret that the informal tea, elevator, corridor, and breakfast groups forgot to appoint secretaries!

REPORT OF THE N.O.P.H.N. RESOLUTIONS COMMITTEE

Resolution I

Whereas the members and friends of the National Organization for Public Health Nursing attending the Thirteenth Biennial Convention have profited by and enjoyed very much this week in Louisville:

Be it resolved that their sincere appreciation be conveyed to the local Arrangements Committee for the careful planning which insured the success of the meetings and the comfort of the delegates; to the Governor of Kentucky, the Mayor of Louisville and to the people of Kentucky for their courteous hospitality; to the management of the Brown Hotel for its generous hospitality to the President of the National Organization for Public Health Nursing, for its ready response to the needs of the Convention, and for its efficient service.

Resolution II

Whereas during this Biennial Convention held in Louisville, Kentucky, in June, 1928, "The Board and Committee Members' Section" was accepted as a part of the National Organization for Public Health Nursing and

Whereas that organization recognizes this as a progressive movement of great importance to the future development of community nursing and health programs:

Be it resolved that the National Organization for Public Health Nursing deeply appreciates the active interest in public health nursing thus expressed by the members and officers of the Board and Committee Members' Section.

Resolution III

Whereas funds from the present federal Maternity and Infancy Act will not be available after June 1929 and

Whereas the value of the work under the Maternity and Infancy Act has been proved by the saving in lives of mothers and children in many states and

Whereas the standard of nursing work in the maternity and child hygiene field throughout the land has improved and public health nursing has been advanced through the work under the Maternity and Infancy Act:

Be it resolved that the National Organization stand ready to aid and promote and coöperate in every way to further the development and operation of whatever bill may be presented to take the place of the present Maternity and Infancy Act, be it federal, state or local.

* See page 358.
** See page 359.

Resolution IV

Whereas the public health nurses of the country feel very keenly the need for very well prepared nurses in the public health field as well as in all other nursing fields and

Whereas they feel keenly also the need for educating the public as to the supply and demand for nurses, the distribution of nurses and the responsibility of the communities for educating those who render so important a community service as nursing:

Be it resolved that the members of the National Organization for Public Health Nursing in this convention assembled take every opportunity to inform individuals and communities of the results of the work of the Grading Committee as told in Dr. Burgess' book, and to promote in every way possible organized activity to carry out remedial suggestions.

Be it further resolved that the members of the National Organization for Public Health Nursing wish to express their gratitude to all members of the Grading Committee and to Dr. May Ayres Burgess especially for her understanding and brilliant studies.

GRACE ROSS
FLORA BURGHDORF
NAOMI DEUTSCH
RUTH HOULTON
ALTA ELIZABETH DINES, Chairman

REPORT OF THE BOARD MEMBERS' MANUAL COMMITTEE

The Convention at Atlantic City in 1926 and the discussions at the Board Members' Institute in New Haven the following year brought a full realization that there is an approved technique of organization and maintenance essential in developing public health nursing associations to their full share of usefulness. Therefore it seemed as if a handbook dealing with methods of organization would be invaluable for those about to start an association; for new board members, and as a book of reference to associations already established.

In the autumn of 1927 the Executive Committee of the N.O.P.H.N. authorized the Committee on Lay Section to appoint an executive group to collect material for such a Manual, with an advisory committee of the presidents of twenty associations representing various sized staffs and sections of the country.

Since January 1st the Executive Section of the Manual Committee has met five times and will resume meetings in October. It is hoped that the first complete draft of the Manual will be ready for trial use January 1, 1929.

In selecting the methods of organization put forward in the Manual the Committee has fully realized there are several forms of organization possible and one might suit a certain locality better than another. We have tried to select those methods which have been well tried and found successful.

MRS. G. BROWN MILLER
Chairman, Board Members' Manual Committee

JUST LIVER

Since this erstwhile humble food has been devoted to its new task of curing anemia, this sign was noticed on a city street:

"Adult calves' liver sold here"

The title of our note reminds us of a recently published novel, "Meat," by Daniel Wilbur Steele. We commend this book—which some may pass by because of the red-bloodedness of its title—as a fictional study of a very real and acute problem which nurses interested in mental hygiene encounter among their families.

TRIANGULAR RELATIONSHIP BETWEEN THE NATIONAL ORGANIZATION, LOCAL ORGANIZATION AND COMMUNITY CHEST *

By Elwood Street
Director, Community Council and Community Fund of St. Louis, Missouri

THIS problem may be likened to that presented by the eternal triangle which is the favorite of dramatists and story tellers since the earliest days of literary history. It might well be said that the national organization and the local organization were for many years happily wedded; until along came the community chest and wooed the local organization away from its allegiance to the national organization with gifts of money and promises of power and membership in a large and diversified family. It was but natural that the national organization should bitterly attack this interloper and warn other local organizations throughout the country of the danger of seduction by this upstart, community chest. Unhappily, however, it was found that the local organizations enjoyed this new relationship. While there were minor irritations, yet the new lover proved in the main to be agreeable, handsome, and generous. Unfortunately, also, the local organization found that it had a lingering affection for the national organization so that the local agency found itself in the position of loving two people at once and not being able to give up completely its allegiance to one for the sake of the other. Further to complicate the situation, in the course of time the national organization, thus forced willy-nilly to associate with the local organization, achieved a sort of liking for the community chest. In like manner, the community chest at first was suspicious of this former lover of the local organization; but eventually came to believe that there was much of value in the national organization, which occasionally helped both the local organization and the community chest as well. Indeed the community chest actually formed a national organization of its own. Thus all elements in this triangular relationship were reconciled to each other and in most communities lived happily in amity and coöperative relationship.

In the triangular relationship between the national organization, the local organization and the community chest, what should be the effective relationship of the chest to each and of both to the chest? Is it not axiomatic that that community chest which proceeds most effectively is the one which allows participation in its affairs by its member organizations? Is not the chief purpose of the national organization and the community chest alike to help make the local organizations serve as many people who need such help as effectively and as economically as possible? It makes little difference whether the community chest and the council of social agencies are one joint organization or whether they are separate organizations; so long as they are based on the democratic principle of participation of the member agencies and so long as the purposes and methods of chest and council work out harmoniously. In other words unified purpose and performance is more important than unified control.

OPPORTUNITY FOR GROWTH—FINANCE

Our first proposition, then, may be stated in the form of a theorem, that the chest must offer scope for the public health nursing organization and for

* Address given before the National Organization for Public Health Nursing Biennial Convention, Louisville, Ky., June 6, 1928.

all other local agencies to develop adequately in finance, in service and in community relationship.

If this first situation of financial adequacy is to be made possible the local agency must have its point of view represented on the budget committee of the community chest, either through a direct representative of the organization or through someone thoroughly familiar with the field of work. Furthermore, full and fair hearings of the budgetary proposals of the agencies must be provided and a chance given for appeal to the board of trustees of the community chest if the budget committee does not seem to the agency to give it the appropriation which is justified by the facts of the situation. The board of trustees must include representation of the agencies themselves. This relationship seems fundamental because the agencies which make up the community chest have engaged in a sort of partnership with all the agencies participating in the chest, all working for its success and each sharing in the financial results according to its needs and the needs of the community.

Not merely, however, should the community chest act upon the budgetary proposals which the agency presents. Through research and through joint discussion on the part of the agencies concerned, the chest should be continually aware of the needs which ought to be met and the relative importance of those needs and the means by which they can be served through expansion if necessary of existing agencies. Sometimes, then, the chest may make proposals to the agency for expansion.

This attitude of stimulation on the part of the community chest should refer not merely to the extension of service but also to the adequacy of such service and to the improvement of standards of pay for such service.

For example, it may be worth while for the agencies in the community chest to make a coöperative study of salaries which are paid with a view to setting, by mutual agreement, standards of performance in like fields and standards of pay adequate to employ workers who can render such performance.

This does not mean that the community chest through its budget committee or other committees should interfere in the internal management of organizations. It should leave scope for the initiative of the executive and the board of the agency to work out its own salary schedule, its own educational methods, its own time of duty, sick leave, its own vacations, etc. The chest should, however, know what these policies are in the different agencies and should check up upon flagrant inequities or inadequacies with the idea of making the best practice of any agency available for all.

Thus, the Community Fund of St. Louis has sometimes suggested to agencies that they should have more adequate executives and has offered the money to employ such executives if the agencies wished to change. In the same way also several of the hospitals in St. Louis found that they were paying different rates for nurses and worked out a standard rate of pay which increased the rate of some, diminished the rate of others and did provide a uniform basis which was agreed to be fair.

The chest should concern itself in financial aspects of the local agency other than fund contributions. It should inquire into the possibility of increasing income from earnings through securing more adequate payments from commercial organizations which utilize the nursing facilities in case those payments are less than they should be. The chest should also put emphasis when necessary upon collection of the amounts which patients themselves can pay. Furthermore, the chest should stimulate the leaving of money by bequests for endowment funds. In other words, the community chest should make up the difference between other sources of income and the necessary expenses of the organization. The chest should make sure that the other income is just as high as it can be without hardship or unfairness to anyone so that contributors may rest assured that their gifts are absolutely necessary.

Conversely, the community fund should study expense in terms of a social program. It provides dollars only as a means to service. Therefore

the chest should analyze all of the features of the agencies' budgets and make sure that each proposed expenditure is justified by social utility.

If the community chest has this relationship to the local organization, that organization should grow faster and more constructively with a broader community point of view and a closer relationship to community needs as a member of a community fund than it would if it were not a member.

A typical instance of the effect of a community fund on a local organization's finances is given by the Visiting Nurse Association of St. Louis. In 1917 its income from contributions was $3,249.08; while its disbursements were $34,381.14, the difference, of course, being made up primarily in income from earnings. In 1922, the last year of independent operation outside the Community Fund, the contributions were $19,411, an increase of about $16,000; while the disbursements were $66,778.12, an increase of about $32,000 during these six years. The contrast with the succeeding six years of Fund connection is striking. In the first year of Community Fund operation $35,131.36 was received by the Visiting Nurse Association in contributions from the Community Fund, an increase of practically $16,000 or as much in the first year of Community Fund operation as in the whole previous six years of separate operation. Disbursements for 1923 were $81,878.53, an increase of about $15,000. The budget for 1928 calls for contributions of $60,605 which is $25,000 more than the appropriation for 1923 and $41,000 more than the $19,000 that was raised in 1922, the last year of separate activity. Disbursements are budgeted at $112,955 or $31,000 more than those of 1923, the first year of Community Fund operation and $46,000 more than in 1922, the last year of separate operation.

The Visiting Nurse Association of St. Louis is not alone in such striking evidences of the growth which is possible as a member of a community chest. Visiting nurse organizations and local agencies throughout the country bear out the statement that social work in general progresses at a more rapid rate when financed through the community fund's coöperative activity than under the old system of separate appeals for funds.

GROWTH IN SERVICE

No question of finance can be considered without the problem of service as well. Hence our second corollary to our first proposition might well be that the community chest and council of social agencies must work continuously with the local organization to help improve its standards of service. We have already noted the importance of consideration of standards from the financial point of view; but even though there were no community fund, the council of social agencies should be giving continual attention to the quality of the service in every field of activity. Manifestly this presents a coöperative relationship which could best be handled by joint consideration of the problem.

In St. Louis the standards of day nursery care have been immeasurably improved by a study of standards made by the Day Nursery Committee of the Children's Department. Day Nurseries are giving better care in the way of food, recreation, opportunity for rest, physical examination and relationship of the day nursery to the home than any single one of the day nurseries had ever given before; and these standards are being enforced by a municipal ordinance, the adoption of which was brought about by the Day Nursery Committee. All this was done without any reference at all to the community fund and purely as a matter of the desirability of better service as seen through a community council.

Moreover, such standardized service must be expanded to meet the community needs as the result of study by the appropriate coöperative group of the community chest or council.

A special Committee on the Handicapped, organized in the Health Department of the St. Louis Community Council, found that no adequate care was being given to the handicapped people of St. Louis, especially the crippled. Accordingly, the recommendation was made that the St. Louis Chapter of the American Red Cross organize a placement bureau for the handicapped. This recommendation was approved by the Red Cross Chapter and money was provided by the Community Fund.

In the same way, it sometimes is necessary to create new organizations to meet needs.

The Bureau for Homeless Men in St. Louis was created after a study of the problem of the care of homeless men by the Family Department of the Community Council. As a result of this study the work for homeless and transient men formerly done

by the Salvation Army and the Provident Association was combined in a Bureau for Homeless Men which for a year operated as a department of the Community Council and then was made a separate organization with a separate Community Fund budget.

Sometimes agencies must be eliminated.

This was the case in St. Louis, when as a result of the study of the Health Department of the Community Council, it was decided that the South Side Public Health Nursing and Teaching Center was no longer necessary and its work was discontinued by mutual agreement.

In a converse manner sometimes, consolidations are desirable.

In Louisville the former Babies' Milk Fund Association and the former Visiting Nursing Association were combined, first with a joint executive and a joint board and finally as one organization, the Public Health Nursing Association, as a result of a suggestion by what then was the Welfare League but now is the Community Chest.

The community chest should also promote the effectiveness of the local agency by its coöordination with other agencies in the same field and other fields.

Thus through the Health Department of the Community Council, the Visiting Nurse Association can work on such common problems as the improvement of tuberculosis facilities; and, through other departments, can coöperate with agencies in other fields on such general problems as housing, the care of unmarried mothers, etc.

The local agency may also secure through the community council the benefit of local action through joint study of local conditions and through outside surveys.

The Health Department of the Community Council made a study of maternity care which resulted in the division of the city on an equitable basis between the two university medical schools. This was a local study.

The Community Council, through its Health Department, brought about a survey of health and hospitals by the American Public Health Association which will have far-reaching results in the improvement of agencies dealing with the sick and working for the improvement of health.

GROWTH IN COMMUNITY RELATIONSHIPS

The local agency must develop in regard to its effective community relationships. Such relationship may be provided by the principle of designation, whereby the contributors to the community chest may designate on the pledge blank of the community chest the amount which they wish to go to each agency. In this way, organization memberships may be kept up; through counting as members all who designated the organization, all former members who have given to the community fund, and all people who give direct to the local organization.

The community chest can help to improve community relationships by giving publicity to the local organization through its own publicity department and through the participation of the representative of the local organization in the community chest's publicity committee.

A further assistance is revealed through broader community contacts. Thus an organization desiring suggestions for board members might go over the list of the community fund campaign workers and pick those who had rendered distinguished service.

RELATION OF THE CHEST TO THE NATIONAL ORGANIZATION

We may now step readily to the next side of our triangle of relationships: the chest must make allowance for the national organization in finance, in service and in future development.

FINANCIAL SUPPORT

It is manifest that the national organization can exist only through the funds which it receives from local communities. Therefore, the payment authorized to the national budget as part of the local budget by the community chest must be based on an adequate interpretation of local responsibility for the budget of the national organization.

In St. Louis, the Community Fund has figured out with the help of the Research Department of one of the great banks that in view of St. Louis' population, its wealth and its social intelligence and with due consideration to the fact that not much can be

expected in support of public health nursing associations in rural districts, St. Louis' fair share of a national budget of a widely distributed national organization should not exceed 1.2 per cent of the organization's national contribution budget.

A maximum figure, however, does not mean that the total shall be granted by the community chest unless a demonstration is made of its need. Therefore, while ordinarily the needs of the national agency may be presented by the local organization along with its budget, upon occasion representatives of the national organization should be prepared to appear before the budget committee, if necessary, to explain their needs. Certainly, if the appropriation of the budget committee to the local organization is based upon a statement of facts, so also should the national budget justify itself by statement of facts and a showing of the necessity of the national program which it is proposed the local community fund should aid in financing. An appropriation from the community chest to the national organization should thus be based not merely upon the service which may be rendered to the local organization but also upon the responsibility of the local community for the development of this service almost on a missionary basis throughout the country. Is it not clear that given the enthusiasm of the local agency for the national program and given adequate presentation of facts about the national agency, the community chest should make an appropriation to the national organization based upon a fair estimate of the community's responsibility for participation in the national budget?

SUPPORT OF NATIONAL POLICIES

Important, however, as are financial considerations, they are matched by the importance of consideration of national policies. The community chest should welcome the advice of the national agency on the development of the service program within its field. The national organization can be of great service in handling a nation-wide problem which affects many local situations. Such, for example, would be the question of charges made to an insurance company for services by visiting nurse organizations throughout the country.

A FUTURE VISION

Not only must the community chest be concerned with the present situation but it must look into the future. If a public health nursing association is placed under municipal control and supported by taxation, which is the trend of thinking today, the community chest should probably continue responsibility for the local share of the support of the national organization, because of its potential services, in standardizing nursing work, in stimulating future development and in being a clearing house for all public health nursing work. This action should be based upon the fact that in many instances such support for the national organization cannot be obtained from municipal sources because of laws governing such expenditures. Even though the direct service work of the local organization were taken over by the city it probably would be wise to maintain a skeleton organization; just as local tuberculosis societies sometimes stay on the job for this purpose even after most of their direct service functions are taken over by the city.

ORGANIZATION RESPONSIBILITY TO THE CHEST

Out of these first two propositions grows the third theorem of our social service triangle: that both the national and local organizations must participate in responsibility for finance, for service and for the whole social program of the community chest.

The local agency must take a sympathetic and active part in the operation of the chest. The local agency should appoint both board and staff members to the various departments and committees of the community council and these members of departments and committees should attend and take an active part in their deliberations.

An especially happy instance of such participation is given in the case of the Community Council of St. Louis where Mrs. Haskell, the president of the Visiting Nurse Association, for several years has been chairman of the Community Council's Health De-

partment and consequently a member of its Board of Directors. She has taken a leading part in the conduct of the health and hospital survey which we believe will bring about the organization of a Health and Hospital Federation with broad powers.

The national organization also must render service to the community chest and council through giving technical advice on problems which come up; and when the national organization has a local office, through the participation of the field representatives in local groups such as executives' clubs, social workers' clubs, etc.

The national and local organizations must also help to fulfill their obligation to the contributors who have given to the chest, through adoption of the best possible methods of service by the local agency and through the suggestion of these methods from the experience of the local and national agencies to other agencies in the same field; so that the whole field of service may be improved by this experience so cheerfully shared.

Finally, both the local and national organizations, the national largely through its influence rather than through active participation, are responsible for local coöperation in common projects. Such projects might be the development of central purchasing bureaus, health and hospital councils and similar activities where joint action is essential. Only through such thorough-going coöperation in every field in which joint action is possible and desirable on the part of local and national agencies can the fullest potentialities of the community chest and council of social agencies as an instrument for more effective community service be realized.

This triangle is not static but alive. Each of the partners in that three-fold relationship may continue growing in serviceability, growing in effectiveness and growing in the regard of the whole community, so that the triangle itself may steadily increase in area of mutual service, while the three elements themselves are indissolubly connected at their points of contact by permanent bonds of mutual aid.

DISCUSSION

Katharine R. Tucker, Director, Visiting Nurse Society, Philadelphia, Pa.

In discussing this triangular problem, Mr. Street has certainly given us an ideal to strive for. It is encouraging to know that this is not an impossible ideal because it has actually been realized in St. Louis. However, I think their situation is a little unique and I believe that that is due in part at least to Mr. Street's capacity to see the ideal and make it a reality.

Accepting St. Louis as a model, some of the rest of us have been thinking how we can "get that way" and what our attitudes are to be in the meantime. Consider a few facts—facts that any public health nursing agency has to consider when wondering whether to enter a Community Chest. It seems to me that on the financial side public health agencies need Chests almost less than any other social agency in the community. Public health work appeals. The service that it offers is very obvious. We do wear uniforms! Also the service that we render is one that more or less represents a common need. Most people at some time in their lives have been sick. Most people at all times in their lives desire *not* to be sick. Therefore our interests are interests that are common to all people, as human beings as well as philanthropically-minded members of a community.

Another fact: Some public health nursing agencies have occasionally found that their budgets have been cut below what they could have raised—that they have *not* progressed as rapidly as they did before membership in the Chest. All Chests are not so democratically managed as the one in St. Louis. Considering all these facts, what should be the attitude of those representing public health nursing agencies?

I am going to ask you to consider the principle and theory back of some of the results Mr. Street has given.

One of the most important contributions

that any Chest has to make is the bringing about of thinking and working for a community program. Board members, contributors and staffs are forced out of their isolation and led to group thinking and action. This is more important than the size of our budgets and brings about a sounder and more far-reaching development than the development of any individual agency. It is more important that we should all develop and grow together than that one agency should grow faster than the others.

Our work as public health nursing associations fails unless we have adequate family societies, child welfare agencies, hospitals, convalescent homes, etc. These are not always so well supported or understood as the nursing organization by their own board members, contributors or ourselves. Belonging to the same family, thinking out our problems together in terms of the whole community, brings about the soundest kind of improvement in service through self-education.

It brings out something else—the relationship between public health nurses and social workers. Nothing brings this about so well as to be bound together through Chests and Councils of Social Agencies. Most misunderstandings come through lack of knowledge, which cannot persist long in a Community Chest city. Because federation brings about this integration in social and health programs, it means better-rounded, more stable, and better understood service for the whole community.

I was interested to read in the June *Atlantic Monthly* an article by Bishop Fiske. He said, "The church is for religion what a social order is for civilization; it is an *environment*." And to my mind the Chest creates the proper environment for all social agencies.

It seems to me that there is a very real parallel between what the National Organization contributes to the social agencies and what the Chest contributes. The Chest is the grouping together of diverse local agencies. The National is a grouping along functional lines on a national basis. Each type of federation removes isolation and removes insulation. The local Chest removes us from the isolation of our own particular field and the National from the isolation of our own particular locality. Through the successes, problems, and failures of others, our own knowledge is increased, our experience extended, our progress made and our development furthered.

As to the relationship of the Chest to the National. I was very much interested in certain remarks in Mr. Street's paper which made me realize with rather a shock that Chests themselves more thoroughly understand the contributions that Nationals have to make to local agencies than we appear to. Mr. Street said: "Chests must provide for the local community's share of the finance of the national organization—based on adequate interpretation of the local community's responsibility for the budget of the National." We ourselves in our own local agencies have not gone that far in our thinking. He also remarks that "it is not only because of the service rendered to the locality that the National should be supported by the local but because of the community's responsibility for the National's activities on a national basis." In other words, we are not responsible for the work just in our local community, but we have some responsibility for the country outside.

Mr. Street also speaks of the potential services which a National may render a local community. There are certain very definite things that federations should depend upon a National for—such as advice in personnel practices, salary studies, cost studies, standards, etc. I believe that if local agencies used their Nationals more, their standards would be better, they would get a larger contribution from their Chest and there would be no question about the contribution of the Chest to the National.

Julia Raymond, Board Member, Visiting Nurse Association, Cleveland, O.

Miss Raymond spoke of her conversation with Mr. Clapp of the Cleveland Welfare Federation and brought out the point which he made that the Chests did not know anything about the Nationals and in many cases made contributions simply to keep the National from making a separate appeal. She then gave a concrete example of the type of service which the N.O.P.H.N. had rendered the Health Council of Cleveland and the

health agencies, in making available a cost-per-visit study applicable to the nursing organization there. She showed a chart which demonstrated the four-sided coöperation involved in such a study—between Chest, Health Council, local agency and National.

Miss Raymond urged national organizations to have people who are interested in Chests on their boards of directors, and not to think of the Community Fund as a money-raising concern only, which is not interested in other problems.

Paul L. Benjamin, General Secretary, Family Service Organization, Louisville, Ky.

In order to understand this threefold relationship we should appreciate what has been happening to the Community Chest. At its best the Chest is a real venture in cooperation, at its worst, the Chest accepts overlording for social planning and social work. Most Community Chests fall somewhere between these two extremes. I think that leaders in the community chest field are beginning to appreciate that there can be no satisfactory relationship between a Chest and a local and a national unless there is democratic participation. At first, the Community Chests accepted responsibility for much of the educational work and the community planning and they said to the agencies, "You go ahead and work in your own field; we will have a person on our staff who will do the publicity for you." There has been a swinging away from this in recent years.

It seems to me that the Chest must stay out of actual internal management of a local agency but there must be the keenest kind of coöperation in community problems and community planning. We have passed the period when any agency could "go it" alone.

As to the national relationship, I recognize the real problem which a National organization has—the difficulty of seeing, except vicariously, the problem which we have in our local communities. I am recommending to a national agency, of whose committee I am a member, that their staffs, every seven years, take a year off in which to go into the field again and do the actual job in an agency.

A word on the relationship of the Chest to the National—it seems to me that the local agency has a real obligation to interpret its national agency to the community and to the Chest and to the other agencies in the Chest. Too often it is true that the executive of the Community Chest feels far more responsible for recognizing the need of supporting national work than the local executives do.

Beatrice Short, Assistant Director, National Organization for Public Health Nursing

Miss Short said that the National Welfare Council was very much interested in the triangular relationship. She said this convention was not the first national meeting at which the triangular relationship had been discussed. At the Citizens' Conference held in Washington in February, it was discussed although not under this title. Nothing said, however, at this meeting today would not have been agreed to by the Washington Conference.

On the financial side of the triangle, we have definitely the responsibility of the local community for the financing of the local agency and of the national. It is not the old sense of responsibility of being our brothers' keeper; it is membership in the community and it is on the basis of that membership that the Chest accepts responsibility for the life of the National, although the work of the local agency may be taken over in part or entirely by the official group. It is a very fine thing to have this expressed, something that we want to understand clearly, and that we want our local communities over the country to realize, for with the growing tendency of communities to turn over public health work to the official group, and the inability of the official group to support national work, the life of the National would be jeopardized.

Every specific piece of social work is strong only as other phases of social work are strong. In local Councils of Social Agencies and in the National Council of Social Agencies we want to think together about the needs of the local communities, and the needs of the larger national community. We want to keep the N.O.P.H.N. responsive and flexible as these needs are expressed, and we want them expressed in a sufficiently definite manner to be met.

WELCOME, BOARD AND COMMITTEE MEMBERS SECTION!

Officers and Rules of the New N.O.P.H.N. Section

The committee to study the advisability of forming a lay section in the N.O.P.H.N. presented its report at the business meeting of the N.O.P.H.N. Monday, June 4. The committee requested permission to form a lay members section in the N.O.P.H.N. to be known formally as the Board and Committee Members Section. This report was enthusiastically received and accepted and the new section proceeded to adopt the following rules and to elect officers:

OFFICERS

Chairman—Mrs. Whitman Cross, Washington, D. C.
Vice-Chairman—Mrs. C.-E. A. Winslow, New Haven, Conn.
Directors—Mrs. A. R. Flickwir, Houston, Texas.
Miss Alice Griffith, San Francisco, Calif.
Mrs. Richard Noye, Buffalo, N. Y.
Miss Anna M. L. Huber, York, Pa.
Nurse Directors—Miss Ruth Houlton, Minneapolis, Minn.
Miss Juanita Woods, Richmond, Va.
Mrs. Ivah Uffelman, Nashville, Tenn.

RULES

I. NAME

The name of this Section shall be the Board and Committee Members Section of the National Organization for Public Health Nursing.

II. OBJECT

The object of this section shall be to bring together board and committee members of agencies rendering public health nursing service throughout the United States for the purpose of discussing their problems, raising the standard of board education, and developing a sense of responsibility toward their work.

III. MEMBERS

Any board or committee member of a corporate member of the N.O.P.H.N. or a sustaining member of the N.O.P.H.N. may become a member of this section by sending his or her name to the secretary of the section for enrollment as a member.

IV. OFFICERS

Section 1. The officers of this section shall be a chairman and a vice-chairman who are lay members, four directors who are lay members, and three directors who are nurses, to act as counselors.

Section 2. These nine shall constitute an Executive Committee.

Section 3. The regular term of office of all officers shall be two years and begin at the close of the convention at which they are elected.

Section 4. A majority of all votes cast shall be necessary to constitute an election. If more than the number of directors to be elected at any meeting receive a majority of all votes cast, those receiving the largest number shall be declared elected.

Section 5. One of the members of the Executive Committee shall be appointed by the chairman as secretary of the section. The term of office of the secretary shall be coextensive with that of the chairman by whom the appointment is made.

V. DUTIES OF OFFICERS AND EXECUTIVE COMMITTEE

Section 1. The chairman shall preside at meetings of the section and of the Executive Committee; shall have general supervision of the affairs of the section; shall make reports to the directorate of the N.O.P.H.N., and shall perform such other duties as are incident to her office.

Section 2. The Secretary shall issue notices for all meetings of the Executive Committee and of the section and perform such other duties as are incident to the office.

Section 3. The Executive Committee shall transact the business of the section in the interim between annual meetings and shall meet at least twice a year.

VI. MEETINGS

Section 1. Meetings of this section shall be held biennially at the time and place at which the biennial meeting of the N.O.P.H.N. is held and at such times and called in such manner as the Executive Committee shall designate. Regional meetings or institutes shall be promoted from time to time.

VII. QUORUM

Section 1. Fifteen members, two of whom are members of the Executive Committee, shall constitute a quorum at any meeting of the section.

Section 2. A majority of the Executive Committee shall constitute a quorum at any meeting of the Executive Committee.

VIII. AMENDMENTS TO BY-LAWS

Section 1. A two-thirds vote of the members present and voting shall be necessary to change or add to the rules.

EDUCATION OF BOARD MEMBERS *

EDUCATION COMMITTEE OF THE BOARD OF DIRECTORS

By Mrs. Roessle McKinney, First Vice-President, Guild for Public Health Nursing, Albany, N. Y.

The idea that board members should really be intelligent about the work of their organizations is so new that we are all rather bewildered by the possibilities which it opens and the added responsibilities which may be placed upon our shoulders. Up to the time of the New Haven Institute for board members which was held just a year ago, the general feeling was that we were simply a group of civic-minded women interested in the general subject of public health nursing, whose main function was to give moral support to the nurse. Primarily we were amateurs. Those who attended the New Haven Institute, however, could not fail to realize the very essential part which board members can and should take in the program of the public health nursing organization as it is developing today. Let me enumerate some of the more important functions:

The old function of giving moral support to the nurse still remains, but to do this effectively the members must be alert to the needs of the community and to conditions in it. The nurse may be an outsider and unfamiliar with conditions in the city or district to which she comes. She should expect advice from her committee as to suitable living quarters, proper office accommodations and immediate sponsorship and support for her work. Very important also is the item of sufficient publicity in regard to her arrival. There is much in getting the right kind of start and the interest of the community in her work must be aroused from the very beginning. Her committee should be able to acquaint her with general conditions, to tell her where she will find coöperation, where opposition, and to assist her in forming the policies of the organization. The nurse cannot and should not have the sole responsibility for forming these policies. This group must be willing to give up time to regular attendance at meetings if they are to keep in touch with the nurse's work, and what is more, they must read and study enough to have a real knowledge of the whole public health movement. In this connection it might be well to mention that all board and committee members should belong to the National Organization for Public Health Nursing, be regular subscribers to, and readers of its magazine, THE PUBLIC HEALTH NURSE, and make it a habit to visit headquarters in New York City when there.

FINANCIAL RESPONSIBILITY

Before the advent of community chests the responsibility for raising funds to carry on the work of the organization fell largely upon the shoulders of board members whose duty it was to tell the public of the work the public health nurse was doing and to so convince them of its value to the community that they would be willing to give it their financial support. In cities where there are community chests the board has now an almost greater task in convincing the budget committees of those chests of the essential nature of the work and the importance of an adequate allotment for carrying it on. Budget committees are harder to convince often than private individuals for they must listen to the needs of all the social agencies in the community, and only by the way in which nursing needs are presented to them can they be made to realize what an adequate service means in terms of human well-being.

THE BOARD AS EMPLOYER

It is the responsibility of the board to see that the nurses are working under proper conditions for their health and general well-being, that their hours are not too long, their vacations adequate, their illnesses properly cared for, and their salaries sufficient for them to maintain a good standard of living. How are we to gain the necessary information about these important facts so that we will know when our nurses are being underpaid, their hours too long or their vacations

* Papers given at the N.O.P.H.N. Board and Committee Members Section, Biennial Convention, Louisville, Ky., June 5, 1928.

too short? The National Organization for Public Health Nursing has made a study of nurses' salaries throughout the country and from it has developed a uniform standard varying for length of service, size of the organization, and will gladly furnish the necessary information.* We can also learn much by finding out what other organizations are doing.

Mrs. Richard Noye of the Buffalo Visiting Nurse Association, reported at the New Haven Institute that in addition to the usual month's vacation her organization three years ago added to this period four days plus Sunday to be given at some time in the spring when the work allowed. From 1922 to 1926 the number of weeks illness in that association dropped from 53 to 22. The drop was so sudden and so great that it must in part have been the result of this little extra time in the spring after the inevitable strenuous winter. The cash value of this saving was over a thousand dollars a year.

In rural districts the nursing committee has a real responsibility in providing transportation not only for the nurse but for patients who would otherwise have no means of getting to and from the clinics which are held.

In addition provision should be made for nurses' attendance at conventions and conferences whenever it is possible. The inspiration which is gained by hearing how other people are meeting the same problems and learning what is being done by other organizations, the educational value of learning at first hand all of the newest developments in the public health movement make the convention invaluable to the nurse if she is to maintain her highest efficiency and keep abreast of the times.

THE PUBLIC HEALTH NURSE IN THE COMMUNITY

One of the most important things for board members to know is whether their organization is adequately filling the needs of the community according to the accepted standards in the field of public health. Studies have been made showing how many nurses there should be for a given population in order to provide adequate service to that community. In cities, one nurse is needed for approximately every 2,000 of the population; in rural districts where distance is a factor, the ratio should be increased to one nurse for 1,500. In appraisal forms published by the American Public Health Association we have facilities for checking up the minimum amount of nursing time which should be devoted to specific problems of public health. It is most important for board members to have this type of information for they can give valuable service to the nurse in helping her to plan a balanced program, one in which maternity, preschool, school and tuberculosis work all stand in their proper ratio to each other.**

From this brief summary it will be seen that in order to be useful board members we have all much to learn. The problem is—How is the uninformed and usually inexperienced person who becomes a member of the board or committee of a nursing organization to learn enough of these essentials to be a really valuable member of that organization? I will suggest a few ways from our experience.

In Albany, last October, inspired by the wonderful results of the New Haven Institute we held a one-day institute for our own Board. Dr. C.-E. A. Winslow and Mrs. Winslow and Miss Jane Allen, General Director of the National Organization for Public Health Nursing, were speakers.

Our board members take turns and each month at our regular meeting one of them gives what we call a talk on "Current Events in Public Health Nursing." This is a ten-minute summary of outstanding developments in that field gleaned from reading all sorts of available material.

We have recently appointed an Education Committee whose work is so new that it is as yet scarcely defined but we expect to study our own organization and see what improvement we can make in that.

We make our board meetings more interesting by having a nurse give

* THE PUBLIC HEALTH NURSE, May, 1928.

** See also *A Balanced Public Health Nursing Program*, by W. F. Walker, D.P.H., THE PUBLIC HEALTH NURSE, February, 1926.

demonstrations of her technique in various kinds of nursing.

We hope to interest our members in going occasionally to staff conferences to hear the nurses discuss their cases and problems.

We are urging, no, *begging*, our members to visit other nursing organizations, and most important of all, to go to the state conferences and the biennial convention of the National Organization for Public Health Nursing.

INTRODUCING THE NEW BOARD MEMBER

By Mrs. Winchester Bennett, Vice-President, Visiting Nurse Association, New Haven, Conn.

For years we have heard much about the need of educating our nurses in the latest developments in public health nursing, and have recognized the necessity for making it possible for them to attend various state and national meetings of public health nursing associations. All this time the average board member has been comfortably and complacently sitting in board meetings, without any suspicion of her own need of education. She has relied implicitly in all matters on the judgment of the professionals employed by her board, and as a consequence has not been of as much assistance to them in certain directions as she should have been.

During the last two years, however, there has been a great change of feeling in this respect. The board members of public health nursing associations the country over have become galvanized into activity, and have of their own accord decided that they wish to be educated too!

We have found that a new member of the board, when she first assumes her duties, is quite at sea as to the interplay of departments, the function of special committees and the relation of specialized supervisors to a generalized program.

Our education committee, therefore, has planned a course of instruction for new board members, which we call the introduction to the association, and which is analogous to the course of instruction given to new nurses, which we call the introduction to the field. This course takes about ten hours, and it has proved so interesting that a number of old board members have taken it, in addition to the new members for whom it was originally planned. Our education committee, and the president of the association, award a diploma to those members who complete the whole course, thereby filling the unenterprising with envy.

The first talk is given by the superintendent of the association. She covers the history of the association, present set-up, and affiliations with other organizations in the field. She gives briefly the qualifications for staff appointment, a description of the various departments, and their relation to the whole association.

The second talk is given by the associate superintendent. She gives a sketch of her own duties, a talk on contacts with social agencies in the city, and an account of various studies undertaken by the association.

The third talk is given by the head of the record office. She explains all the types of records kept by the nurse in her daily rounds, and how the figures from these daily record cards are tabulated so that information of any nature may be quickly gleaned from them.

The work of the treasurer's office is next described: how the yearly computations, such as the cost of a visit, the cost of lost time, and the yearly budget are figured.

The next three talks are on child welfare, tuberculosis, and home economics, and are given by the respective supervisors in these fields.

The final talk is by the educational director, who explains the education of the new nurses.

In addition to these eight talks lasting one hour each, there is also an opportunity to attend one round table, one staff meeting, and a supervisor's meeting.

By the time the new board member has attended all these talks and meetings, she has a pretty fair idea of the general working of the association!

NURSING RECORDS AND REPORTS *

By Joseph W. Mountin, M.D.

Surgeon, U. S. Public Health Service

THIS paper is based solely on state and county or district health service as it is being delivered in the rural areas and smaller towns. The writer admits an entire lack of information on city health practices and needs, but entertains the hope that a few of the principles expressed may be generally applicable. The central theme is built around the recording and reporting of definite and positive departmental accomplishments—the means by which these are effected are of secondary importance, and the personnel involved occupies a similar position. The system of records and reports advocated is based on this principle of administration. That confusion and chaos exist in the whole field of records and reports is quite generally admitted. An attempt is made to analyze the situation as well as suggest a remedy without pointing the accusing finger at any professional group. The views expressed are personal and in no way are they intended to reflect the attitude of any organization with which the writer is now, or ever has been connected.

LOCAL HEALTH ORGANIZATION

The type of local organization acceptable to most students of health administration is one organized on a county or district plan supported in the main by public funds and delivering at least three essential services—medical health officer, nursing, and sanitary officer. In only a small percentage of the area of the United States is service being rendered according to this plan. In some instances a part of this service is provided for a smaller unit of population on either a generalized or specialized program. The budget is a sort of patch-quilt with all who are so disposed contributing their individual or corporate bits to lighten the burden of the local official agencies. The state is usually the promoting agency and exerts its influence, either through filial devotion, statutory enactment or economic pressure. The local health organization must project its program in accordance with the wishes of the contributing agencies, and make its reports on forms supplied by, or approved by, these agencies. The situation is further complicated by the fact that in the home office of these contributing agencies there are division directors who require a special report of activities. This picture, to some, may seem overdrawn but all too frequently is only a resemblance of the true condition. This is a plea for sympathy toward, and understanding of the worker in the field in order that he may be spared the time from paper work to develop a few activities to be supervised, compile a few essential records to be analyzed, and perform a few services for his people. It should be stated that financial aid fills a very definite present-day need, and that consultation service is essential but it should be brought about by some plan of integration which will obviate separate records and reports and undue interference with local prerogatives.

CAUSE OF CONFUSION

Part of the cause can be found in the present system of financing, which at this time is difficult to remedy. A good bit of it is bound up in the personality and mental attitude of those in supervisory positions—and this can be remedied. It might be well for us, at this point, to call to mind that old saying: Those who can do, are out doing; those not able to do, teach; and those neither able to do nor teach, supervise.

* Address given at the N.O.P.H.N. Records Committee Meeting, Biennial Convention, Louisville, Ky., June 6, 1928.

All too often the reaction of individuals merely reflects the attitude of the organization with which they are connected. The situation is aided and abetted by the over-development of bureaus and divisions, both central and local, on the basis of personnel classification rather than function. The result is chaos, which at last is becoming recognized, but so far attempts to bring order have only produced more record and report forms, which coupled with a desire to impose the system on others adds to the confusion and tends to fix the disordered state of affairs.

THE REMEDY

The remedy will not be found in standardization or in the activities of any super-committee which will attempt to anticipate the needs of every community. It lies in national health agencies and professional groups reaching some agreement on essential features of records and reports and data to be compiled; then leaving the person, who selects such a task, free to draft his forms and keep his records as he will. If for no other reason than the exaltation of the ego, persons in executive positions will continue to devise record and report forms, so why not accept human nature and attempt to give it some direction? We must look to national health agencies and professional groups to initiate, to guide, and to sustain the movement for coördination and simplification of records and reports. But they must be in agreement before they can expect acceptance of their views by local groups. Their rôle, for purposes of brevity, may be set down as follows:

Formulation of basic principles.
Outlining of the system.
Selection of common items of service to be included in all records and reports.
Supplying the necessary definitions.
Consultation service.

Going beyond this is inviting opposition and in the end will nullify efforts in this very useful field. No plan of unification will be successful that does not have the active support of the state health officers.

RECORD AND REPORT SYSTEM

In any system there are four essential elements—individual case records, daily record of individual activities, a periodic summary, and an annual analysis—all shaped to the ultimate goal of showing departmental service rendered. What shall be included and what can possibly be omitted?

Case Records will vary under such circumstances as, locality, scope of work, and type of service, but no item should be called for or entered upon a record unless meeting one of the following requirements:

Necessary in current handling of a case or situation.
Necessary in future handling of a case or situation.
Necessary as data for report.
Necessary for special studies.

These will strike you as being all-inclusive and ample justification for the prevailing type of record, which cannot be assailed because nothing is omitted. But if the form is approached with a determination to *omit* all items not absolutely essential one will be evolved which will probably be used and will afford sufficient space for a person of average hand to write legibly.

Daily Reports should be a mere statement of service rendered and not be burdened with information more properly belonging to the case record. The record should be of such a size and shape that it can be carried in a pocket without inconvenience. Any daily report which cannot be completed in the field is bound to be inaccurate and doomed to failure. By a proper system of coding the same form can be used by all workers. Detailed data such as time and cost figures, except for purposes of bookkeeping, should not encumber the daily form in routine use but should be subjects for special study. For purposes of internal administration daily reports may be tabulated at the end of the month, but such tabulation is a function of the clerical force.

Periodic Summary of Progress. This has become the most troublesome of all reports. Somehow or other there

has sprung up a monthly progress report which has been expanded beyond its purpose and into which has been introduced a cumulative feature whereby the report for the last month of the reporting year becomes an annual report. A monthly progress report should be no more than a brief summary based on a representative sample. In so far as possible it should be based on definite accomplishments rather than on activities. The report should be departmental and not a series of reports, either individual or consolidated, based on personnel classification.

Annual Analysis. Little need be said about this except that it should be as extensive and searching as possible without encumbering basic records. It should be developed from the point of view of relating result to effort, expenditure to accomplishment and existing program to actual needs. It should be based on an analysis of basic records and not a mere summary of monthly reports. This should be the main report and the one to which the administrator and the analyst should go for his information. Basic tables should be standardized and there should be an agreement on general style. The requirements should be made known to the local workers in advance in order that proper adjustment may be made in records and in order that certain tabulations may be kept current, thereby preventing delay and unnecessary work at the close of the reporting year.

BASIS FOR RECORDS AND REPORTS

In order to have any uniformity in records and reports there must be a starting point for the system and a definite objective. Possibly our difficulties are an absence of a working plan. The appraisal forms devised by the Committee on Administrative Practice of the American Public Health Association, to a certain extent at least, fill this need. In their present imperfect stage they come nearer meeting general acceptance than anything we have. Studies now in progress should correct present imperfections, and we may, therefore, safely adapt our systems of records and reports to the appraisal forms.

National health agencies and professional groups should take the lead in coördinating records and reports, but they should avoid the following errors which will tend to nullify their efforts—working at cross purposes, attempt to anticipate local needs, over emphasize activities of professional groups, or seek to impose a system. Such a task should be undertaken since the field awaits, the toiler will be welcomed, and if efforts are properly directed there should come from this labor what we all seek—simple records and reports giving comparable data.

DISCUSSION

Editor's Note: We regret that lack of space makes it impossible to publish the full discussions of Dr. Mountin's paper. We cite a few practical points only.

I. Malinde Havey, Assistant National Director, Public Health Nursing Service, American Red Cross:

A suggestion I wish to make is the elimination of all items on reports that are not actually used for statistical analysis. After all, records are made to be used, and it is futile to ask busy people to make reports on items which are destined for the archives. It is better to have data on a few points with specialized studies from time to time, rather than to ask for everything all the time. With this in mind, the American Red Cross Public Health Nursing Service simplified its record system two years ago with the gratifying result that last month we received all but five reports from our 375 services in the eastern area.

Marion W. Sheahan, Assistant Director, Division of Public Health Nursing, New York State Department of Health:

State health departments need reports from individual services to show accomplishments obtained through expenditure of funds. This is necessary to obtain new appropriations. State health departments also need records as aids to supervision and attempts to raise and maintain nursing standards out in scattered fields. Finally, the records help the nurse herself in developing her program

and maintaining her standard. The opposition to records is largely psychological.

Marguerite J. Clancy, Director Nursing Service, Kanawha Public Health Nursing Association, Charleston, West Virginia:

From the viewpoint of the visiting nurse association I believe that insufficient income to obtain the proper clerical force is one if not the chief cause of our poor records and reports. Every clerical worker is not endowed with the insight of a professional and this might also be said of executives who must necessarily direct such summaries.

Amanda Sheeler, Director, Visiting Nurse Association, Moorestown, N. J.:

No records had been kept in Moorestown for the first twenty-five years of the nursing agencies. The story was that each nurse had had to work so hard that there had been no time for records. A record system was started about one year ago, after a board member had attended the Board Members Institute in New Haven. After two months it was evident that the volume of work called for a car and another nurse. Later a part time nurse was employed to handle infant welfare clinics.

Records provide information for monthly items in newspapers giving accomplishments of work. Funds have been raised much more easily since this information has been available for the public, and the quality of the work of the association has improved.

REPORT OF THE COMMITTEE ON RECORDS

Since the last Biennial, the committee has held seventeen meetings. Two have been all day sessions. Several new members have been added so that the committee now represents large and small public health nursing agencies, insurance companies, Red Cross, state health departments, special demonstrations, the American Public Health Association and the N.O.P.H.N. The members of the subcommittee on records of the Committee on Administrative Practice of the American Public Health Association act as advisers, together with other outstanding public health workers, such as Dr. Louis I. Dublin.

During the eighteen months prior to the last Biennial, individual case records were prepared. These were submitted to the membership at Atlantic City. The suggestions received there were incorporated and the forms published by Mead and Wheeler. The committee then took up the study of data needed for various reports:

The daily report was published in March, 1927, also a day book form for nurses working alone with a limited number of cases, a nurse's school report and a simple 5 x 8 form for extra data. During the last year the committee has studied periodical reports. Conclusions and recommendations are now available in mimeographed form.*

A year after the case records were put into circulation the committee sought criticisms and suggestions for any changes brought to light after actual use. More than thirty organizations responded and two committee meetings were devoted to these. Several minor changes were made:

The family folder has been made to allow for expansion. An extra data sheet has been issued. Two types of maternity records were found to be needed, and a form to meet the need of the organization which for some reason discharges the infant at the end of the post partum period is being tried out.

More than a quarter million of the index cards have been sold, 135,000 of the family folder, and 110,000 of several of the other forms are in use already. The committee will always welcome constructive suggestions for improvement of any of these forms.

* These forms are being held for further changes and corrections before publishing in the magazine. The N.O.P.H.N. records are not copyrighted and may be adapted to suit individual needs.

Observe, record, tabulate, communicate. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone can you become expert. . . . But when you have seen, read. And when you can, read the original descriptions of the masters who, with crude methods of study, saw so clearly. Record that which you have seen; make a note at the time; do not wait. "The flighty purpose never is o'ertook, unless the deed go with it."

Sir William Osler

ADEQUATE TRAINING FOR INDUSTRIAL NURSING *

By W. H. Winans
Industrial Relations Department, Union Carbide Company, New York City

To discuss adequate training for an occupation we must first know what the work is and then what qualifications are required to do that work effectively. Our subject refers specifically to the industrial nurse. We can quickly agree that by the term industrial nurse we mean a nurse employed by a business concern to render professional nursing service to its employees in connection with sickness or injury arising in the course of their employment. This is the basic element common to all concerns employing them. Beyond this point, the practices vary widely in different concerns. For the purposes of this discussion, may we say that industrial nursing is specialized professional nursing service rendered under a doctor's supervision, to or in behalf of employees at the expense of their employer; its primary purposes being, first, to provide emergency medical or surgical care, in cases of sickness or injury arising in the course of their employment, and secondly, to advise and coöperate in the maintenance of their physical efficiency.

REQUIRED QUALIFICATIONS

What are the required qualifications and characteristics of the woman who is to enter this specialized field? I use the word "woman" because first of all she must be truly a woman in the full and well understood meaning of that word. She must know how to be a good mixer without getting mixed up herself. She must be human and sympathetic and yet kindly firm with the neurasthenic and keenly discerning with the malingerer. She must be no respector of persons but must know folks so well that she is adept in the different methods which should be followed in dealing with the Italian yard laborer and the office manager. She must be so thoroughly grounded in the technique of her profession that she can be master of the situation in any emergency which arises even if her routine instructions and procedure do not prescribe the action to be taken and the doctor is not available. She must understand her employer's point of view and be so familiar with the company ideals and policies that her actions, words and influence will promote sound and satisfactory relations between the employees and the management. She must know the community problems and agencies so well that she can guide and direct employees to the most effective and suitable sources of advice, treatment, or assistance in each individual case. She must have that manner, appearance, and personality, which inspire confidence and lead naturally to the coöperation of employees in following instructions no matter how difficult or what sacrifices may be involved. And, too, she must be so professionally thorough and accurate that she upholds the ethics and high standards of her profession in connection with proper records, scientific attention to technical details and right coöperative relations with other nurses and doctors in the community. And one more requirement I am constrained to add: She must also be able to boss the doctor under whose supervision she works. Only a woman can do that—and she must always be right when she does it! But the industrial physician or surgeon needs the helpful guidance of the nurse many times and if he is the right man for his job he gladly accepts and commends that guidance.

* Address given before the N.O.P.H.N. Industrial Nurses Section, Biennial Convention, Louisville, Ky., June 7, 1928.

With that picture of the characteristic features of the industrial nurse before us, some may ask, "Can such a nurse be found?" My quick reply is: "Certainly, I know a number of them myself." During nineteen years of social service, public administration and industrial experience, I have had the privilege of working with nurses of the health departments, of the schools, of the hospital clinics and outpatient departments, of the visiting nurse association, and in industry. They are representative of the highest type of womanhood in America. They do not all measure up to the ideal any more than do all industrial relations managers or lawyers or preachers or doctors or employers. But there are enough who meet the requirements I have indicated to warrant consideration of the standard as practical and not Utopian.

DESIRABLE QUALIFICATIONS

But I am not satisfied to rest my case here. I have referred to *required* qualifications. May I now mention an additional *desirable* qualification? At the graduation exercises of the 1928 class of nurses at Brooklyn Hospital last month the speaker addressing the class appealed to them to make their profession not only a calling but also an art. He quoted the definition of an art as "Doing the thing you have to do better than you need to do it." If industrial nursing means to you only bandaging cut fingers so as to prevent infection, removing foreign bodies from eyes, making appointments at clinics, arranging admissions to hospitals, entering treatments on dispenssary records, checking up absentees and making reports to foremen or department heads, then you need a new vision of the job.

May I remind you of Henry Van Dyke's poem legend of *The Toiling of Felix?* You remember Felix had sought to learn from the Holy Hermit where he might find the Christ and was told "Raise the stone and thou shalt find me; cleave the wood, and there am I." So in a nearby stone quarry "among the lowliest workers, Felix sought and found his lot."

So the *desirable* qualification which I wish to add for the industrial nurse is this: She should have a broad and inspiring vision of unselfish and far-reaching service and a sincere desire to find the real joy and satisfaction of life in rendering that service.

BASIC TRAINING

What about the training, you ask. Obviously, she must have thorough professional training under the prescribed standards of recognized schools of nursing. Certainly she should meet all the requirements to permit her to qualify as a registered nurse. Otherwise, she cannot be accorded the recognition of the doctor, the employees, the employer, and the courts in the professional phases of her work, which is essential to the completely successful carrying of her proper responsibility. Her technical skill must be attested to by her diploma before she can safely be charged with the very lives of those under her care. The employer cannot take a chance on a technical error due to the lack of any part of the complete and thorough training of the graduate nurse.

Next in importance it seems to me is training, and especially practical experience, in public health or social service nursing. The employee cannot be considered just as an individual. He must be dealt with as a member of, or the head of, a family. Furthermore, he lives in a community of some kind. He is not isolated on an island. He must be advised and dealt with in the light of his circumstances and needs, and under the limitations of his resources. It may be necessary in an individual case to bring five or six social agencies into a problem in order to work out a satisfactory solution. The industrial nurse must be trained in dealing with the family problem in this manner and must know what public and private facilities are available to assist in complicated cases.

The doctor may make a diagnosis and say "This man must stop work at once and go to a sanatorium for at

least six months." At that point, the task of the industrial nurse begins. She must know how to tell the worried wife—mother of three children—about it and so win her over that she too will encourage the husband on his long, tedious road to recovery rather than to distress him and retard his return by heart-breaking letters of hardship and privation caused by his absence. She must help work out the budget and financial plan for the long pull and during the dragging months must bring cheer and hope both to the family and the patient. When the return to work is finally possible, she must guide the employee in right habits of work and leisure so as to assure continued working ability at high physical efficiency. The happiness and life outlook of all five members of that family are within her hands. She must be a veritable bulwark of strength, resourcefulness, genuine ability, and enthusiasm. These can be had only through training and experience. Poise, calm assurance, and mature judgment are not found in a book.

Then, too, the industrial nurse should have some instruction in business organization, management, and industrial relations. She must appreciate the need for lines of authority, for company rules, for business procedure and accounting control. She need not know the technical phases of office management but she must know that she cannot send an employee home on account of illness without first advising his supervisor. She must realize that she cannot tell the discouraged young wife of the junior bookkeeper that she will ask his boss to give him a raise. And she must warn the doctor that he cannot refer a two hundred dollar a month draftsman to the highest priced specialist for a tonsillectomy unless some advance arrangement is made regarding the operating fee and hospital charges. She must be trained to be business-like.

She must also know about the best present-day practices in personnel or industrial relations management. Her coöperation is vital in securing and keeping the right spirit in the organization. She must know the fundamentals of practical psychology as applied to industry. She must understand the principles and requirements of workmen's compensation insurance and other social and labor legislation. This training and instruction can be given her as part of her public health or social service specialized development. It probably means attendance at some evening classes, but it is essential to the effective handling of the work.

Perhaps you feel I have been too exacting in this statement of what I regard as adequate training for industrial nursing. Possibly I have, but the opportunity for helpful service is so big and broad that it is worthy of a high standard and high ideals. The industrial nurse needs specialized preparation to equip her for her task. The attainment of the ideal, however, is not too difficult. You remember the story of the eight year old youngster waiting at the curb on a busy street for an opportunity to cross through the endless traffic with her chubby little brother. Finally the chance came. She gathered the little fellow up and trudged across. A passerby on the opposite side watched them and said to the little girl as she placed her load down, "Well, he was quite a heavy load for you, wasn't he?" "No," she replied, "he isn't heavy, he's ma' brother." With her spirit in your task, your profession *will* be made an art.

HEARD AT THE CONVENTION

From the Shopkeeper: "This is the nicest, most good-natured group of people we have ever had here."

From the Waiter: "No, Ma'am, you doan gib us no trouble. Nurses is high class ladies."

From the Hotel: "Delighted to cash your check; nothing to fear from this group."

From Anyone: "Is it raining?"

CONSTRUCTIVE NUTRITIONAL WORK IN INDUSTRY *

By Eleanor Reed Maclay, B.S., M.S.
Professor of Nutrition, School of Household Administration, University of Cincinnati

THE recent contributions to our knowledge of nutrition are of special significance to the industrial worker because of his dependence upon food for his activity and for offsetting possible unfavorable conditions under which he may work and the economic pressure which often limits the selection of food. In a discussion of the nutrition of the industrial worker it must be conceded that food is not the sole determining factor. Rest, fresh air, sunshine, good habits of hygiene, freedom from undesirable physical conditions should receive due consideration, but too frequently these are stressed and the importance of a well-balanced diet overlooked.

What are the food habits of the industrial worker? Many dietary surveys of various groups have been made in the past but it is not known that there has been any comprehensive study of the industrial worker's dietary. In an effort to get information concerning this group a study was made under the supervision of the School of Household Administration, University of Cincinnati, during the summer of 1927, conducted by the Industrial Health Conservancy Laboratories, Cincinnati, Ohio.**

The data for this study gathered from homes, included information on housing and environment, the number and ages of the members of the family, types of work done, the food eaten at the three meals by the workers and the family, special likes and dislikes of the workers for food, the portion of the income spent for food, and other general information which might prove of value.

The second part of the survey covered a large number of meals eaten at industrial cafeterias, chiefly noon lunches. The investigator listed the foods appearing on the trays, noted the sex of the worker, estimated the age, and when possible the exact type of work. Later the price of each meal was computed. The meals were classified as bettering or not bettering the day's dietary of the worker. In two cities the lunches brought from home were studied.

FINDINGS

The distribution by income groups showed that a wide variation had been included, ranging from $11 to $51 or over, per week, however 46.4 per cent of the families had incomes from $21 to $35 per week. Different portions of the incomes used for food varied from 20 per cent to over 61 per cent. On the whole there seemed to be no relation between the percentage spent for food and the quality of the dietary.

The daily food allowance per capita was computed as follows: Cincinnati, $0.46; Birmingham, $0.32; Hartford, $0.37; Racine, $0.43; Milwaukee, $0.34.

Of far greater significance than the amount of money spent for food is the value received in body nourishment. In order that a dietary receive the rating of "excellent," the following articles at least were considered necessary daily:

One quart of milk per child and one pint per adult.

Two vegetables besides potato.

One fruit.

One raw food (fruit or raw vegetable).

Some whole grain cereal, either breakfast cereal or bread made from whole-grain flour.

Adequate calories—generally well balanced—variety.

The "good" dietary included at least:

* Excerpts from address given at the N.O.P.H.N. Industrial Nurses Section meeting, Biennial Convention, Louisville, Ky., June 7, 1928.

** The National Dairy Council financed this work.

One pint of milk per person.
One vegetable besides potato.
Adequate calories—generally well balanced—variety.

There followed a grading of "fair," "poor," "very poor." The rating reports of the 752 family dietaries were:

1.2 per cent "excellent"; 19.4 per cent "good"; 66.9 per cent a little better than "poor"; 10.7 per cent somewhat below "poor"; .66 worse than "very poor"; 1 per cent undetermined.

The rating reports of the 1059 workers' dietaries were:

1.5 per cent "excellent"; 16.9 per cent "good"; 68.1 per cent a little better than "poor"; 9.8 per cent somewhat below "poor"; 2.6 per cent worse than "very poor"; 2.2 per cent undetermined.

In all the cities the workers' ratings correspond, in most instances, to the family ratings. Another interesting characteristic of the worker's dietary as noted, was that it bore no relation to the income group in which he belonged.

SPECIAL DEFECTS

The analysis of the dietaries for special defects showed a greater prevalence of these in the worker's selection of foods than the family's taken as a whole. The following tables give a comparison of the two:

Frequent defects	In family dietaries	In workers' dietaries
Insufficient vegetables	220	313
" calories	89	189
" variety	117	163
" milk	531	735
" vitamins and minerals	96	132

One of the most striking observations was that in the twenty industrial cafeterias visited, the food offered emphasized the deficiencies of the home dietary, although it was possible to choose food which would serve to better the situation. Frequently these cafeterias are managed by persons who do not have an understanding of the nutritive needs of the varied group, for whom they are providing the food. Only one manager seemed so qualified. It was noted that no cafeteria made a systematic effort to aid the worker in the selection of food, according to his requirements. However in a few instances an attempt was made to get the worker to choose suitable foods by displaying them in a prominent place and putting the less desirable foods in the background.

In two cities, compilations were made of the contents of lunches brought from home. The number of these lunches was 9,300, representing 1,100 workers in thirty-five different trades. The majority of these were obtained in Birmingham. As previously stated these lunches were of such character that they in no way improved the day's dietary.

PRACTICAL SUGGESTIONS

The first essential of the adequate diet is a sufficient amount of food. The working girl often affords a serious problem in this respect. Frequently she eats too little food and the wrong kind as well. In her effort to save money for clothing or perhaps to retain the slim, boyish figure she skimps on food, thus lowering her resistance and many times bringing on serious bad effects with which this group is familiar. A recent study in Milwaukee showed the tuberculosis rate within the last decade to have materially increased among young women between the ages of fifteen and twenty-five. It is believed by those who investigated the situation that underfeeding was partly responsible.

Appetite cannot be relied upon as a guide to what the worker needs because there are too many possible influences in his mode of living, which are conducive to poor appetite. Even though the quantity may satisfy the desire for food, the quality may not be such that it will fulfill all the body

needs. Dr. E. V. McCollum says "Eat what you want after you have eaten what you should."

Inasmuch as the nurse cannot give information in a technical form as to the number of calories or grams of iron needed, it may prove helpful to interpret the essentials of the dietary in terms of foods. Guides for planning the day's meals are here given, as they may be passed on to the worker or homemaker of the family.

Include one quart of milk for each child and at least one pint for each adult.

Serve two vegetables besides potatoes and, preferably, one of these raw. The leafy ones like cabbage, spinach, lettuce and other greens should be used two or three times a week.

Give at least one fruit (raw if possible) as the minimum; two desirable. Too great emphasis cannot be placed on the extensive use of fruits and vegetables by every member of the family.

Plan to use a whole grain cereal in breakfast food or in bread. All cereals furnish a cheap source of energy.

Provide a serving of meat, eggs, cheese or fish.

Drink plenty of water, it aids in the regulation of body temperature, acts as an excellent food solvent and helps in carrying off waste products. It is undesirable that the worker drink iced water, below a temperature of 48 degrees, while at work.

Allow at least three or four pounds of fat per week for every five members of the family.

Include sugar in moderate amounts. The sugars of fruits and molasses are good sweets to use. An excess takes away the appetite and irritates the stomach.

Food should be eaten slowly and not washed down with liquid because chewing helps the teeth and gums and aids digestion. All overeating is harmful whether it means eating too much of all foods or of one kind.

A regular time for meals is essential. Even when there seems to be a definite need on the part of the worker for additional food because of an underweight condition, or excessive activity, the extra lunch should be eaten at a regular time and should be simple, as milk and crackers, fruit or fruit drink.

EXPENDITURE FOR FOOD

Sherman has given two general rules for any level of expenditure: "At least as much should be spent for milk (including cream and cheese, if used) as for meats, poultry and fish; at least as much should be spent for fruits and vegetables as for meats, poultry and fish." When the family income is very limited, cereal foods must generally be increased. Meat is usually the most expensive item even when the cheaper cuts are bought, therefore it should be used in combination with other foods, such as cereals and vegetables. Industrial workers usually have the mistaken idea that extra meat is needed by the individual engaged in hard labor. They do not realize that the additional requirement for energy may be met more readily and more cheaply by carbohydrates and fat foods.

The factors contributing to this problem are many and varied but the nurse can undoubtedly help overcome some of the difficulties, at least. Her personal contacts afford an effective means of reaching the individual and every opportunity may be used to show the worker what foods he should eat and why he should eat them, giving a logical reason will frequently bring the desired result. In many instances food is often largely responsible in sending the patient to the medical department. Although the nurse may not have the authority to manage the cafeteria meals, she is in a position to analyze the situation and to enlist the aid of the employer, the medical department and the cafeteria manager in coping with the problem.

The Service Evaluation Committee held an open meeting during the Convention at which announcement was made of a further study of the cost per visit to be undertaken by the N.O.P.H.N. in the fall, if funds become available. Public health nursing associations having cost problems which are not met by the former Report of the Committee to Study Visiting Nursing are urged to send their questions to the committee promptly in order that the study may be made as inclusive and valuable as possible. A study of the method of computing cost of delivery service will be included in the study.

HIGHER EDUCATION FOR THE PUBLIC HEALTH NURSE*

I

By Margaret S. Taylor
Staff Nurse, Visiting Nurse Service, Henry Street Settlement, New York

INTERESTING discussions as to the wisdom of higher education as a requirement for the public health nurse were held in the eighteen nursing centers of the Henry Street Visiting Nurse Service. The consensus of opinion seemed to be that the field nurse must have some theoretical work in order to intelligently and adequately carry out the educational work in the homes. It was quite definitely felt that the standard requirement for admission to schools of nursing should be a high school diploma, that the course should include a much broader curriculum to offer an opportunity for theory and practice in public health or social service, and that some mental training, including normal as well as abnormal psychiatry should be an essential part of the nurse's training.

It is sometimes hard for the nurse in a discouraging district to grasp the breadth of public health work. Theory not only helps to buoy her up, but also shows her ways and means of reaching her goal. The nurse must have at her finger tips the latest and most helpful methods and information. Otherwise her educational work in the homes would be not only inadequate, but also ineffectual. The educated patients would not heed her teachings and the uneducated would be uninterested and unimpressed.

SOME METHODS

Our organization has stimulated many nurses by having an unusually fine mental hygiene supervisor. At each center, once a month, there is a round table discussion of mental hygiene cases found in the district, plus a short talk by this supervisor.

A most instructive series of nutritional talks has been given at each center.

At our main center is a splendid growing reference and circulating library.

The Henry Street Service provides an opportunity for part-time work, with salary adjustment, allowing the nurse to be out of the field two afternoons, one counting as her regular half day. There is a course given at Teachers College of Columbia University, which provides field work through Henry Street. Evening courses are also given at the University, but at present not in sufficient number. Any university course the nurse must finance herself. However, if the nurse is very anxious to continue her education, and for some reason is financially unable to do so, there is a small scholarship fund for which she may apply. This scholarship fund is provided by the nurses themselves through a scholarship committee elected by them. This committee arranges for theater parties, card parties, dances, and the like, to establish this fund.

II

By Marion S. Lowe
Staff Nurse, Department of Health, Detroit, Michigan

The field of nursing was inaugurated by an intelligent and well educated woman, Florence Nightingale, and it is pertinent to remember that the first school for nurses, to whose endowment at St. Thomas Hospital Miss Nightingale devoted the national gift presented her after the Crimean War, was established not to furnish nursing service for the hospital, but solely for the education of nurses. Are we, the modern nurses of today, to let that far-flung banner unfurl itself in half-preparedness? Shall we be

* Excerpts from papers read at a special N.O.P.H.N. meeting for Staff Nurses, Biennial Convention, Louisville, Ky., June 7, 1928.

thoroughly educated or only partly so? How can we struggle into this quite new profession of public health nursing with no preparation other than that afforded by a hospital training school?

It seems as if there is but one starting place for this adjustment in the field of education. Our schools of nursing are at fault in that a great percentage of them do not require a high school education for entrance. The average hospital school is not organized on such a basis as to conform to the standards accepted in other educational fields. The chief reason for the lack of sufficient recruits of a high type to meet such needs lies precisely in the fact that the average hospital school of nursing does not afford a sufficiently attractive avenue of entrance to this field. Our general educational system has for some years been devoted to educating youth, not to training, but this adjustment has not been made in schools of nursing.

A high school education is but a small contribution in the hands of a public health nurse as she starts out on her career, but what a magnificent asset in the years to follow when she finds herself qualified to take courses in university extension work! What a world of confidence it gives to the nurse in that it prepares and strengthens her for further educational opportunities.

ITS PRACTICAL NEED

The great advancement of culture and industry among the densely populated masses, has created serious and complexing problems in both community and civic life. The present day public health nurse must have her eyes open to the social and medical aspects of her community. She must be prepared, not only to be able to make a message clear, but to do it persuasively and with skill—so that the desired measures will not only be understood, but put into practice. She must be able to answer definite, intelligent questions, to teach mothers to do things in the right way, and to meet the foreign born with a deep understanding of their viewpoint. Lack of education fails to build a bridge between the newcomer and the American. The nurse who cannot express herself or cannot teach in the language which the mother can interpret kills herself in the mother's eyes. Can she afford to lack definite knowledge and accuracy? Our calling demands a sound and broad education.

In a recent survey made by a well known health department, it was found that 85 per cent of the nurses decided that a high school education is a basic necessity for public health nursing. Even though 50 per cent of the entire group are high school graduates they still feel that they are not sufficiently equipped to meet the demands of their field.

Every day situations are arising that demand a great deal of deep thinking and a high school education is a background for just such thinking. Some of the best public health teachers believe that the nurse's lack of appreciation for her rôle as teacher comes from meager preparation.

METHODS OF SUPERVISION

OFFICE DEMONSTRATIONS AND CASE CONFERENCES

By HELEN H. LAW
Staff Nurse, Visiting Nurse Association, Minneapolis, Minn.

Supervision in public health nursing is necessary. In any group where growth and success is ultimate there must be a leader. What greater joy can there be to a staff nurse than to have an experienced, socially minded, calm, coöperative, pleasingly sure supervisor who stimulates her staff nurses to an exposition of their greatest abilities and at the same time upholds the principles of her organization? She aids her nurses in deciding the proper course to pursue regarding difficult problems or unfamiliar situations and points the way to coöperation between her organization and

other social agencies. "She thinks only of the best, works only for the best, and expects only the best."

Office demonstrations are valuable only when they induce discussion and constructive criticism. I have asked staff nurses from various types of public health nursing organizations to state their views on these matters, and they seemed unanimously in favor of the staff nurses giving the demonstrations before the entire staff rather than relying upon the supervisor to carry on the work. Perhaps they feel that by such method the nurse checks her own technique, becomes more confident, and a freer discussion follows the procedure.

The value of case conferences can not be overestimated. Whether these conferences include the supervisor in the first instance is immaterial but before conclusions are reached as to plans for the patient or family the supervisor, because of her unique situation and experience, should be consulted. Group discussion stimulates the various members of the group and can be done more efficiently in the office than in the patients' homes.

An evaluation by the supervisor of the staff nurse's ability to detect and analyze the problems with which she comes in contact can be made chiefly through conferences. Logical and less emotional conclusions are thus reached. The criticisms of the supervisor should be given impersonally and accepted by the staff nurse as impersonal. The friendly and helpful relation between supervisor and staff nurse, and the spirit of coöperation within a staff are only created by a general consideration of problems and by uniform methods which result from office demonstrations and case conferences.

SUPERVISION BY LECTURE

By OLGA M. KIEGER
Staff Nurse, Board of Education, Cleveland, Ohio

The newer interpretation of supervision is that of education, through which the growth of the nurse is encouraged and accomplished, and through which the service she renders is made better and fuller, which, after all, is our final aim. Broadly speaking, we may therefore say that anything which helps the nurse to grow is a form of supervision.

How many times have we heard a remark similar to this one at the close of a lecture: "Well, another afternoon wasted, and to think that I had to leave my busy district to come in to listen to this!" Let us stop and think a moment. Was there not one thing which we were able to take away with us, to be used in the improvement of ourselves or our work? A new idea is a real contribution to life. It stimulates us, enriches the mind, and inspires us to new thoughts.

Suppose the lecture was nothing more or less than a review of material which we learned some time ago. Are not reviews beneficial? Is it not profitable to have old material, once learned, refreshed in our minds? In psychology we are taught that in order to form a habit, it must be re-emphasized at intervals, so that if it should begin to lapse, there is something to hold and reinstate it. So it is also with all this old material.

VALUE OF LECTURES

Near the close of a course of lectures for school nurses questionnaires were sent to the nurses asking their opinion as to the value of lectures as a form of supervision, and any suggestions or criticisms which they might have to offer. The conclusions arrived at were interesting:

Lectures improve the field nurse mentally, increase her usefulness, broaden her viewpoint, and thus enrich and improve her work.

They enable the field nurse to become more adaptable in her relationship with coworkers, both nurses and others.

They stimulate the nurse to new fields of endeavor, thus expanding her program.

They arouse in her a desire to do better work.

They supply the opportunity to become

more familiar with subjects bearing on her work, and so enable her to give more intelligent information to those seeking it.

They present an opportunity to meet individuals, outstanding in their own line of endeavor, who inspire and encourage the nurse to go onward.

They furnish review, which is valuable.

A few suggestions collected from the questionnaires were:

To have more "up to the minute" lectures on recent developments in the health field.

That only good speakers be selected—speakers who know their subject and have it well organized, so that it may be given in a systematic manner.

That prominent speakers be selected.

That in a course of lectures, more organization of material and less repetition will increase interest and enthusiasm.

That classes consist of nurses only.

That lectures be given when the nurses are most receptive—at some time other than after a hard day's work in the district.

VALUE OF SUPERVISION IN THE FIELD

By Mildred Rountree
Staff Nurse, Public Health Nursing Association, Louisville, Kentucky

Field supervision as one of the newer thoughts in public health nursing has often been misunderstood by the staff nurse and its value misinterpreted. Writers on the subject have been limited in their expression as to desirable methods of work and often the program has not attained the realization of its possibilities.

Presenting the different values I should like to give first thought to its effect upon the nurse. The very nature of the discipline in the hospital school of nursing tends to retard the initiative of the nurse, whereas the nature of public health nursing demands the display of initiative through the analysis of problems and the formulation of plans for their solution. Even though opportunity is afforded the nurse for the development of initiative if her background of training has not prepared her to be conscious of problems she does not appreciate their significance. Consequently the opportunity for the development of her initiative is lost. The field supervisory visit helps to overcome this difficulty.

To the nurse's advantage also is the fact that the supervisor sees the case first hand and is better prepared to advise the nurse judiciously in the handling of the case. She sees the nurse at work, realizes the difficulties she encounters in the field, and is able to judge wherein the nurse shows special ability.

The comradeship developed between the supervisor and the staff nurse through the field visit has a distinct value in promoting a closer relationship and helps to eliminate the feeling that "I have my work and you have yours and our interests are different and apart." After all the work is our work and field visits help to make us more conscious of our mutual interests.

Through the field visit of the supervisor, we are better able to maintain uniformity in procedures. It is true that the nurse often unconsciously develops individual practices which are contrary to the policies of the organization and which may go on unnoted unless field visits are made. When the organization sets up a standard of procedure, it falls as an obligation on the organization to observe the use of that technique in the home and note the practical nature of its application.

Finally, the supervisor can offer comments and suggestions as to teaching methods while in the field which develop different and more effective approaches to individual problems.

EVALUATING THE WORK OF THE RURAL PUBLIC HEALTH NURSE *

By W. F. Walker, D.P.H.
Field Director, American Public Health Association

CONTRARY to our earlier thinking the need for rural nursing service is not essentially different from the need of the city. There is no indication that a less intensity of nursing or medical service is required by rural people than is found desirable for a group of similar economic status living under urban conditions. It is true that different strategy must be applied in carrying out rural work.

Three outstanding conditions exist in rural work which differentiate it from similar service in the city.

Diffuseness of population.
Size of the area covered. This makes supervision more difficult and seriously interferes with the ability of the nurse to adjust her program from day to day to take care of emergency diseases.
Lack of coördinating facilities, such as hospitals, dispensaries, social service organizations, etc.

The most important single factor and the one most difficult to measure is the need which rural nurses have for a greater efficiency and economy of service if equally satisfactory results are to be accomplished. This also may be called the strategy of nursing service.

The fact that a return visit cannot readily be made on the day following without serious loss of time and interference in the planned program, makes it necessary that every visit be utilized to its fullest extent, and so far as possible be made to serve the purpose of two visits. Someone in the home must be taught the next steps to be taken.

The rural nurse must make use of such facilities for medical and social service as are available, and will find altogether too frequently that the details of arrangement with these agencies must be carried out by herself, if at all.

It is essentially in the community organization and relationships with health and social agencies that the method of evaluating the work of the rural public health nurse differs from that applied to that of cities, and in this field we are almost entirely lacking in even tentative measures. We find organizations advocating and decrying local committees. The technique of their establishment and use has not been standardized. There is need for a careful recording of methods in the field of community organization before the evaluation of a rural public health nursing service can be satisfactorily accomplished.

RURAL COMMUNITY ORGANIZATION

Glendora M. Blakely, State Advisory Nurse, Oregon State Board of Health

Shortly after the rural nursing program was started in Oregon it was decided to unite the local forces interested in its development in an organization which would serve to interpret the nursing program to the community and give it moral and financial support.

This plan as worked out in Oregon is based on a county wide organization, the nucleus of which is the community group. We believe that a community should be as well organized for promotion of health work as it is along other lines. We also believe that to insure the best results in this organization it should be representative of the whole community. Therefore we stress:

The development and strengthening of the community group.

* This and the following papers were presented at the N.O.P.H.N. meeting on Rural Nursing, Biennial Convention, Louisville, Ky., June 7, 1928.

Membership in the organization.

Attendance at group meetings, and as interesting meetings as possible so that members will come each time and join forces with their neighbors in extending the work.

The community group chairman is appointed by the president of the county public health association or is elected from the local membership as the community desires. The chairman chooses a standing committee which corresponds to the standing committee of the county association which reports to the county committee chairman.

(Miss Blakely then cited an example of this set-up which space prevents our including in her discussion.)

Many of our community groups are selected from some already existing group or organization such as the parent-teacher association, women's club or church groups.

Our state health department encourages the nurses to give as much time as necessary to community group organization, considering it time well spent.

We feel that more interest is aroused in our work, permanency is given to our program and that the community, by actually doing, understands the value of the work and is more apt to support it.

Norma B. Eskil, American National Red Cross Nursing Field Representative for State of Minnesota

In the very first pamphlets issued by the National Red Cross on "Organization of a Chapter Nursing Service," the Chapters were required to have a nursing committee which did not differ greatly from our present committees. The organization of a good committee takes much of the nurse's time and energy but it brings abundant return in understanding and help. There does not seem to be any standard rule for the organization of a committee for they vary according to the community. I will describe one which is functioning and which I consider a good committee.

This particular Chapter has had a nursing service for seven years and for the past two years has had financial assistance from the county. The nursing committee was not very large but, with the prospect of some day turning the service over to public funds, the Chapter felt that a larger and more representative committee would be needed.

The county has an area of twenty townships and a population of 26,000 people, half of whom live in the county seat. The other half are about equally distributed over the county with no other large towns. This county does not have a full time health officer.

The county was divided into four equal districts of five townships each and a sub-committee appointed for each district. A representative of each township was found to act on the sub-committees and they elected a chairman and secretary. The chairman of each of the four sub-committees with the secretary of the Red Cross Chapter, the County Superintendent of Schools, the secretary of the local tuberculosis association who is also chairman of the Junior Red Cross, the county health officer and a lay woman, previously chairman of the Chapter nursing committee, made up the County Nursing Committee. A medical advisory committee was appointed and also a dental advisory committee.

The sub-committees meet once a month and the county committee once a quarter. The county committee determines policies and program and the sub-committees do the work. This committee was organized last fall and the first project was a toxin-antitoxin campaign for the entire county.

For May Day the committees made arrangements for the window displays, distributed literature, asked the ministers to preach May Day sermons, etc. Later they plan a series of chest clinics.

While all this is going on the committee members are making a study of health conditions in their districts and are making a card index of all resources, local, state and national, which they will use in their work. At the time of the county committee meeting next fall they will report conditions. It will not be long before this committee will be planning work several years in advance. When the entire financing of the service is taken over by the county as will eventually happen the Chapter will not drop out of the picture but through the nursing committee will continue to give the people the benefit of their long experience in this field of activity.

Frances C. Montgomery, Assistant Director, Bureau of Child Hygiene and Public Health Nursing, Alabama State Board of Health

Miss Montgomery outlined the set-up of the County Health Unit in Alabama. We quote in part:

The strength of Alabama's county organization for health lies primarily in the approval and support of the local doctors, the activities of a group with one object—the Health Unit—the coöperation of all civic organizations, and the coöperation of representatives of state agencies, such as education, and child welfare.

The amount of county appropriation for a full time county health service is determined by the assessed valuation of the county. In rural counties the annual appropriation varies from $3600 to $5000. This is supplemented by funds derived jointly from the state board of health and the Rockefeller Foundation. The minimum budget for the operation of a rural health service is $7600.

The public health nurse employed must be a graduate registered nurse. She may or may not have had a public health course. She must have the two months introduction to the field that is offered by the training station in Alabama.

Alta C. Walls, Field Worker, Wisconsin Anti-Tuberculosis Association

Public health nursing service in Wisconsin must meet the needs of a state largely rural. In 1911 the Wisconsin Anti-Tuberculosis Association offered the service of a public health nurse for the period of one month to the twelve cities in the state having the highest per capita seal sale. Demonstrating nurses are still used at times by this association to introduce nursing service to communities and to demonstrate the value of public health nursing. The nurses, upon entering a new community interviewed members of the medical and dental profession, interested people including the school personnel, club women, clergy, mayor, Red Cross workers, and seal sale workers. The approach was made through the schools, health talks were given, health leagues were organized, and school inspections made. This work was so effective that employing boards in many communities were convinced that a public health nurse was a decided asset.

Various surveys have been made regarding the incidence of tuberculosis in communities. These surveys have been effective in bringing to the attention of the public the need for public health nursing work.

Wisconsin in 1919 gave official recognition to the importance of this work by the passage of a law which is called the County Nurse Law and grants to counties the right to spend public funds for this work.

Elnora E. Thomson, Professor of Applied Sociology and Director of Nurse Education, University of Oregon, Portland, Oregon

Any county nursing organization should have the advice and coöperation of the existing public agencies. The public agency needs the coöperation of the private one in order to keep up standards of work, and to educate the lay groups. They need also knowledge of each other's programs, so that they will help, not inhibit, each other's work.

On entering a new rural field it is well to find out what the state department of health is planning to do, and what other state departments are planning to do. It is wise to start work with a small service group and work from that to publicity and better organization.

Only as we help the local medical groups to make their service in families more effective do we make our work permanent. There should be a medical committee who will advise and deal with ethical questions.

CARE OF THE SICK IN RURAL AREAS

Point of View of the Rural Hospital—By Alma Haupt, Director, Nursing and Public Health Service, Commonwealth Fund, New York City

Is there any more forceful humanitarian appeal than that of the sick person who merely because he lives in some remote rural part of the country is denied the comfort, assistance and skill so amply provided through medi-

cal, nursing and public health services in our large centers? Is there any more distressing situation to a rural doctor or nurse than to know that a life could have been saved if only the necessary equipment were at hand?

Fortunately the appeal of the country dweller is being heard and a beginning is being made in the extension of medical and public health facilities to rural districts.

Numerous individual local groups have recognized their own needs and have built their own community hospitals, and organized programs for rural hospital development have been established by at least two foundations, the Duke Foundation operating in North and South Carolina, and the Commonwealth Fund which at present is contributing to hospital projects in six different states.

A brief description of the Southside Community Hospital in Farmville, Virginia, the first unit in the Commonwealth Fund program, will serve to illustrate how a fifty-bed general hospital cares for its rural sick. This hospital was opened in November, 1927.

An incorporated board of directors is directly responsible for the hospital. They have provided the hospital site and have raised one-third the original building and equipment cost, the Commonwealth Fund supplying the remaining two-thirds. They have faced the fact that the hospital will render more service than can be covered by earnings, therefore they have guaranteed an anticipated operating deficit. They have agreed to operate the hospital according to generally approved standards of service.

The hospital serves the town, which has a population of four thousand, and a district thirty-five miles in radius which includes a total population of 78,000.

All registered physicians in this area have been invited to become members of the medical staff. An average of five of these local physicians a year are recipients of scholarships from the Commonwealth Fund so that they may take post-graduate courses. An institute program was also arranged whereby two or three outstanding medical authorities in the country were brought to the hospital. The local physicians are enthusiastic about both of these educational devices, seeing in them opportunities for increasing their own professional knowledge and improving their ability to use the hospital equipment.

The superintendent of the Farmville hospital is a graduate nurse with both hospital administration and public health experience. The nursing staff at present consists of nine graduate nurses and one trained attendant. Professional stimulus is maintained through helpful supervision, rotation of services and weekly staff conferences. Future plans include the building of a nurses' home, the provision of a limited number of scholarships and the holding of one or two institutes yearly for nurses.

The interest and ability of the local women have not been overlooked. A woman's auxiliary is active in raising funds for hospital linen, preparing surgical dressings and helping to make the hospital known throughout all the nine counties.

Every patient in the district is eligible to care, whether able to pay or not. He has at his disposal a bed in either a four-bed ward, a semi-private two-bed room or a private room. Laboratory, X-ray, medical, surgical, obstetric and pediatric services are offered.

In a report of the American Public Health Association entitled "Relations Between Health Departments and Hospitals," published in the *American Journal of Public Health* for March, 1928, the three main avenues of cooperation between health departments and hospitals are given as laboratory service, the hospitalization of communicable diseases and the maintenance of clinics of public health interest.

Certain beginnings have been made in the Farmville Hospital:

A general public health scheme for the whole hospital district is to begin in the early summer. The laboratory is already used for hospital patients and such public health services as examination of tuberculosis, hook-worm and syphilis specimens, water and milk, and routine examinations for the out-patient department.

The opportunities for a fifty-bed hospital to care for acute communicable disease patients are naturally limited, although facilities for isolation are at hand and emergencies can be met.

The hospital is in a particularly fortunate position to coöperate in a public health program through its out-patient department clinics. These clinics may be of two types, those involving diagnosis and treatment, and these of a preventive and educational nature, such as prenatal and child health clinics.

The idea of the hospital as a "health center" for the community requires that the public health groups in a rural community,—local boards of health, branches of state organizations, and the local hospital play closely together.

The game cannot be played with the same rules in every state or in every community. No one hospital and no one local group will immediately solve the many problems involved, but at least the appeal of the rural sick has been heard and a beginning has been made toward their adequate care.

Point of View of County Visiting Nursing—By Julia Groscop, American Red Cross, Harford County Chapter Public Health Nurse, Bel Air, Md.

To the majority of nurses and especially those who have done rural public health nursing, the problem of providing adequate nursing care for the rural people has offered much food for thought. Experience has proved that one county nurse carrying a so-called educational program cannot hope to meet even the acute nursing needs.

Few, if any, attempts have been made to develop a one nurse county program devoted exclusively to visiting nursing with the teaching of home hygiene as an important corollary. The Red Cross wants to find out how to do visiting nursing in the country. As one line of development in that direction, the Fayette County, Ohio, Chapter of the Red Cross with headquarters at Washington Courthouse, inaugurated a county visiting nurse service on March 7 of this year. The county has an area of 444 square miles with a population of 22,000 including that of the county seat, which is 9000. It is strictly an agricultural county with several small communities and having a very active Farm Bureau organization. The county seat is centrally located with good roads making all parts of the county accessible to it. There are no hospital facilities in the county with the exception of a small, privately owned hospital recently started.

A county nursing committe is being formed of key persons. These representatives have been carefully selected, the county agricultural agent with six years' experience in the county and knowing it well, giving willing assistance in finding capable persons for this committee. He has invited the nurse to present the subject of the nursing service before all farm bureau meetings and he has promised to do likewise. The representatives from the various communities will act as chairmen of local sub-committees, the duties of which will be to assist the nurse in equipping loan closets, in organizing Home Hygiene classes and interpreting the service in the various communities.

The why, what and wherefore of the service has been presented to many groups in the county including the county medical society. This last group of professional men were requested to appoint a medical advisory committee and this committee with the nurse have prepared standing orders.

In the establishing of this service the Chapter has definitely chosen to confine the work to regulation visits during regulation hours and not to attempt to handle deliveries or acute calls out of hours as long as there is but one nurse. The committee, considering its county seat rural, has included the town in its program with the idea that as the work grows and becomes too much for one nurse to handle, a second nurse will be added. The entire service is organized on a fee basis with a sliding scale of fees for the nursing care and a $3.00 fee for home hygiene instruction. The entire project is financed by the Chapter.

Indian Bureau Nursing Service—Elinor D. Gregg, Superintendent of Field Nurses and Field Matrons, Office of Indian Affairs, Washington, D. C.

Editor's Note: We refer our readers for a description of the Indian Nursing Service to THE PUBLIC HEALTH NURSE, January, 1928.

Miss Gregg said that the present objective in the Indian Bureau is a public health nurse for every one of the 80 reservations and more than one for the large units. There is pressing need for thirty more public health nurses in this pioneer field.

NEWER METHODS OF SUPERVISION *

By Marion G. Howell
Director, Public Health Nursing District, Western Reserve University, Cleveland, O.

IN considering newer methods of supervision one is reminded of the incident an experienced nurse relates of her earliest lesson in supervision. She was a young nurse on the ward doing as well as she could what little she knew, and succeeding very poorly in making her patient comfortable. The principal of her training school came in and saw the situation at a glance. In the most kindly, gracious, and sympathetic manner this leader among nurses suggested that they together try to remedy matters. Skillfully, seemingly so easily, the principal soon had the patient at ease and the young nurse had learned many things:

She had learned that the principal of her training school was primarily interested in people and their well-being, that her principal was human, she was democratic; she worked *with* her nurses, she demonstrated the finest way in which to reach a common goal, she was willing to teach when teaching was needed, was willing to demonstrate the most simple nursing procedures, and she was equally interested in the welfare of the patient *and* the nurse to the end that one be made well and that the other be well made.

Our early professional leaders have known and practiced many of the best and most successful methods of supervision which we are endeavoring to use today. It is true that military discipline and autocratic methods have entered in at times and some are still using them, but supervision today means democratic leadership in a group of co-workers.

The improvement of the nursing service by promoting the professional and personal growth of the nurses is the primary purpose of all supervision. We seek to know how to release the personality of the individuals of the group supervised, to develop their initiative and individuality and help each one to become an independent thinker and creative worker. Supervision fails unless it succeeds in stimulating growth—the largest possible growth in desirable ideals, interests, knowledge, power and skill—our emblem is the symbol of growth.

We believe to-day that self-expression is a fundamental human hunger. Each nurse has some latent creative tendencies and should be given opportunity to express these. Some may be especially gifted in art and can add much to the attractiveness of headquarters through posters. She may make more bright and cheerful the environment of chronics and shut-ins. The nurse gifted in story-telling may use her talent in caring for convalescent children. Other nurses have special skill in dramatics, others in teaching. The real supervisor recognizes the value of these creative abilities and helps, encourages, and directs them.

The supervisor must be definite in assignments and firm about standards. She must recognize at what points the nurse needs most help and be fair in her reports and recommendations. She must know when she should go with the nurse and when she should stay away; when to give encouragement and how to give it. The supervisor introducing the new nurse probably has the biggest opportunity of any nurse in the organization. So much depends on her and her teaching both direct and indirect. The nurse learns much from her good example, as well as precept. The attitude of the supervisor and the atmosphere and spirit of headquarters help her to realize her new work is a real vocation and not a mere job.

* Excerpts from a paper read at a special N.O.P.H.N. meeting for Supervisors, Biennial Convention, Louisville, Ky., June 7, 1928.

The supervisor also has duties as an administrator. She is responsible for the smooth running of her office as well as knowing and caring for the needs of her district. There is a certain amount of investigation of complaints or lack of coöperation either within or without the organization. The wise leader faces all problems squarely, admitting error where error has existed, determining its cause and profiting by the mistake. Professional workers who come in contact with such great varieties of personalities and so many human frailties must practice the finest kind of mental hygiene. A supervisor who neglects her own physical and mental health cannot possibly do her best work. Coster's "Psychoanalysis for Normal People," written for nurses, should be read by all and especially by all in supervisory positions.

DISCUSSION

Catherine A. Flynn, Director, Public Health Nursing Service, Department of Public Welfare, Knoxville, Tenn.

The importance of the introduction of the staff nurse to the field cannot be overestimated. Demonstrations and return demonstrations in the office with an opportunity for discussion are most important. The wise supervisor will watch with care the unfolding of the new nurse's resourcefulness, and will be slow to use the word "don't." The staff nurse will learn early that she is expected to discuss her problems freely and seek constructive criticism.

Nursing organizations located in a city or town where there is a university find it is possible to obtain speakers on subjects that are so recent as to be new to many of the staff nurses. Lectures on the endocrine glands from physicians especially interested in this subject as well as lectures from nutrition specialists have been most helpful to nurses dealing with the underweight and overweight child.

It is my opinion that much more is absorbed and many more problems discussed as the supervisor visits with the nurse in the field than are ever brought out at group meetings in the office, especially when the supervisor remains in the background of the visit.

Bettie W. McDanald, Superintendent, Public Health Nursing Association, Louisville, Ky.

Before guidance in self-development is possible, the supervisor must know individually the nurses with whom she is working. She must know their strength and their weaknesses, she must find the best methods of approach to each person and then she must be able to give them the help and inspiration that will meet their individual needs.

The supervisor who is wise will endeavor to develop independence in thought and self-reliance. She will direct her nurses to the sources from which they may derive assistance, she will be interested in their welfare both physical and mental. She will take pleasure in their recreation and she will respect the personality of each one and regard them as co-workers. Mutual respect and mutual good will is the foundation upon which helpful supervision is built. If the nurse has respect for the judgment and ability and technical knowledge of the supervisor, her friendly offices will be in demand and the supervisor can be assured that she has won the confidence of the nurses.

Let us see what some of her responsibilities are in regard to the staff:

The supervisor should keep a watchful eye over the nurse and observe when she begins to show the effects of strain and fatigue. It may be that the nurse needs a break in the year's work in addition to the vacation that is usually allowed. After the heavy strain of the winter's work a long week-end may be just the amount of rest necessary to tide over the let down feeling she has when the pressure of work lightens. It is a wise supervisor who anticipates this and secures permission to arrange the nurse's work so she may have this little period of rest and recreation.

Most associations allow their nurses a period of two weeks to one month sick leave. The importance of giving the maximum time cannot be emphasized too strongly. Con-

valescence from an illness may be tedious and to add worry to weakness is defeating the very thing we are trying to gain. The length of the sick leave should be, to a certain extent, determined by the length of time the nurse has been on the staff of the association. The nurses feel that this interest in their welfare is a direct expression of appreciation of work well done, and the satisfaction that results from appreciation serves as an inspiration to greater achievement.

I believe it is true that the majority of nurses on staffs of public health nursing associations do not have public health training when they present themselves for admission. The supervisor has a marvelous opportunity to interest both new and old members of the staff in further study and reading. In our organization we have found that posting on a card a reference in a magazine or the name of a new book has been most helpful in serving to arouse interest in reading. If the nurse is directed to a certain article or chapter in a book that helps to solve a problem with which she is struggling, the interest is intensified. We have arranged with the principal of the local normal school to have a special course in "The Principles of Teaching" given to the nurses on our staff. The course was designed to apply especially to the health teaching problems met by the nurses in the homes.

The supervisor can also direct the nurses to lectures of general interest, to courses not related to the job that may be welcome, and concerts for those interested in music. It is here also that a knowledge of the interests of the individual nurse is essential.

Mrs. Charlotte M. Heilman, Nursing Field Representative for New York State, American National Red Cross

A plan for the supervision of public health nursing services which are widely separated, covering several counties or a state, must be worked out on entirely different lines from that of a city or a single county. Much of the detail must be handled by a central office, such as:

Preparation and distribution of well defined policies on organization and administration for the guidance of the nurse and her committee:

Assistance to the local committee in its choice of personnel, reserving the right, when possible, to make the final decision as to qualifications;

Filing of monthly and annual reports which give a picture of the nurse's progress, her problems, and serve as a basis for constructive criticism or advice;

Distribution of material of a helpful and informational character.

In such services an active and well selected local nursing committee is indispensable. Care should be taken in the selection of this committee to see that its members are not too locally minded but that they have a desire to keep their service abreast of the times, and that they can be relied upon to recognize their need for help in working out their problems. Unless the committee is willing to accept the advice of the central office and the supervisor, regional supervision is very unsatisfactory at best.

More than ordinary care must be taken in the selection of the nurses, or at least the nurse in charge if there is a staff of nurses. Only a well qualified person is suitable for a position in a field of this sort—one who is self-reliant, resourceful, of pleasing personality and who has qualities of leadership. She must be thoroughly familiar with the aims and policies of the organization by which she is employed and must be in sympathy with them; otherwise, working as she must for several months at a time without a visit from the supervisor she could easily lead her committee astray and get into tangles which would be difficult for the supervisor to unravel. In order that the nurse may be prepared to benefit as much as possible from the visit of the supervisor, she should jot down details on which she wants help or advice as they arise.

Assuming, then, that there is a well regulated central office it goes without saying that a supervisor must at all times keep in the closest touch with the central office. Before the supervisor makes her field visit she should refresh her memory by reading back over the monthly reports and correspondence which has passed since her last visit, making notes. She should also make notes of new developments in the field of public health, new literature, new record

forms, or new policies which she may want to bring to the attention of the nurse and her committees. No visit should be made without a definite purpose or objective. It is usually advisable to make a visit coincide with the regular monthly meeting when this is possible. This gives the best opportunity to estimate the committee's understanding of the program, to interpret policies which are not clear or to make suggestions for the extension of their program. At these meetings the supervisor has an opportunity to judge the relationship between the nurse and her committee, and to evaluate the nurse's ability to present her problems and reports.

Perhaps the most satisfactory visit is one in which the supervisor is able to start out in the morning and go with the nurse on her daily rounds. It gives an opportunity to make comments or suggestions in a manner acceptable to the nurse and it also gives the supervisor an opportunity to learn from the nurse—for every nurse develops some idea or procedure which is worth passing on. It is a very wise plan to find some time for recreation with the nurse during the visit.

Regional conferences or institutes play an important part in the development of services of this type. If the nurse and her committee can be brought together from time to time with the workers from other services where they can receive new enthusiasm and stimulation, discuss their mutual problems and successes in round tables or individually, the supervisor will find her work greatly simplified.

MATERNAL MILK COLLECTION

A small but deeply interested group gathered during the Biennial Convention to discuss the service of collecting and dispensing maternal milk. Reports were given from the Hartford Visiting Nurse Association, Detroit Bureau of Wet Nurses, Boston Directory for Wet Nurses, and the New York Children's Welfare Federation. Among the particularly arresting items in this truly life-bringing service were:

Mothers who sell their milk make anywhere from $25 to $100 monthly. These profits in some cases have been set aside as an educational fund for the mother's own baby, in others have been used to secure sunnier quarters for the family, or for little luxuries for the mother.

Detroit reported one exceptional mother whose own baby had died, who gave 200 ounces of breast milk in one day, and earned $300 in one month!

The contributing mothers are frequently deeply interested in their foster babies and inquire daily as to progress and weight of the child whose life they are saving.

In one city breast milk is being boiled down and given to very weak babies in concentrated form with success—this, of course, on the physician's order.

All cities reported the finest sort of coöperation and personal interest from railroad and other officials in seeing that the breast milk received care in handling and prompt delivery when needed by out-of-town infants.

Onions, garlic, and alcoholic beverages are tabooed in the diet of contributing mothers for obvious reasons!

IMPORTANT—WHERE TO FIND OTHER PAPERS

Owing to lack of space the reports from the N.O.P.H.N. general meeting on *Staff Education Program and Community Service*, the report of the N.O.P.H.N. Education Committee, and the N.O.P.H.N. Tuberculosis Section, and Round Tables on Delivery Service and Care of Chronic Patients will be published in a later issue of the magazine. School nursing papers, other than the report of the business meeting of the section (see page 347) will appear in the special School Nursing Number in September.

Partial reports from the A.N.A. Nurses Relief Fund Conference will appear in the *American Journal of Nursing* for July, 1928. The papers on "Tuberculosis in Young Women" by Jessamine S. Whitney, Statistician, National Tuberculosis Association, and "Tuberculosis Among Student Nurses," by Elizabeth Davis, M.D., University of California, will appear in the *American Journal of Nursing* for August, 1928.

Proceedings of the National League of Nursing Education, containing the entire League Biennial Convention program will be published in the early fall and issued to members. Others may purchase from headquarters, 370 Seventh Avenue, New York City.

LUNCHEON MEETINGS

EXECUTIVE DIRECTORS' PUBLICITY LUNCHEON

The luncheon meeting for executive directors of public health nursing associations to discuss publicity was crowded to capacity. Unfortunately a few directors spoke without notes. We quote from those who presented papers:

Emilie G. Sargent, Director, Detroit Visiting Nurse Association—The Visiting Nurse Association hopes by publicity to convince the public that home care of the sick and the protection of the well through health teaching is indispensable and to gain therefrom both patients and contributors. There is a difference in publicity to interest patients and to interest contributors. Membership in a Community Fund does not affect the publicity directed to patients while it does affect the publicity prepared for contributors.

In Detroit the Visiting Nurse Association tries to reach those who need its service by circularizing the physicians, hospitals, social welfare agencies, private and public, through announcements in the newspaper, and by radio broadcasting, and through talks on the nursing service to clubs and church groups. Nurses in uniform demonstrate some actual phase of nursing care at fairs, health shows, and in downtown windows. Posters showing a nurse in action have been placed in factories and stores.

There has been little demand for intensive publicity to increase the use of nursing service with two exceptions: when nursing service has been extended to new territory, and in our present endeavor to stimulate the use of the pay service both on the visit and appointment basis. In February this year, the Visiting Nurse Association together with the Detroit District Association, launched an appointment or hourly nursing service. Special publicity was prepared to place this service before the public. A committee of lay women called personally at the offices of 500 of the most outstanding physicians, while announcement cards were sent to the other physicians in the city. Announcements were run in the newspapers, the monthly Community Fund Bulletin gave two pages to the subject, and the Bulletin of the Wayne County Medical Society gave an announcement and an editorial on the new service.

The printed annual report is intended primarily to sustain the interest of contributors. It is short in order to invite reading, and is small enough to insert in a standard business size envelope which allows for its inclusion with correspondence.

The Community Fund Campaign is held in November and is directed not only to the large giver, but to the small, hence many of our clients and potential clients are contributors to the Fund as well as being paying patients.

Last year we supplied the publicity department of the Community Fund with twenty stories, many of which were illustrated by photographs and were used in the daily and Sunday papers. Campaign stories are required to possess human interest and are frequently further embellished by the newspaper reporter. We try always to be on the alert for good story material but we have had more success the last two years through a story contest which served two purposes as the prize awarded the winner was her expenses to the Biennial Convention.

As an agency member of the Community Fund the Visiting Nurse Association participated last spring in a so-called educational campaign whereby staff members were given a list of potential contributors, former contributors and dissatisfied contributors on whom to call in person and to explain the work of their particular agency and its relation to the Community Fund. This was a hard task and the results difficult to measure, though the Community Fund felt the effort well worth while.

In conclusion, may I say that while all avenues of publicity are helpful, the most essential and dependable publicity is the daily work of the staff nurse, while the wholehearted, enthusiastic, intelligent support of board members, if they be representative citizens, is the best publicity for enlisting contributors. Personal salesmanship secures the best results.

Mary V. Pagaud, Superintendent, New Orleans Child Welfare Association—If, by publicity, we mean the effort to gain and to hold first public interest and then public confidence, then publicity is essentially a part of daily living. Every member of the staff becomes, *ipso facto*, a publicity agent. The pleased patient is a more effective advertisement than a headline story. The nurse who is gentle as well as skillful, the physician who is kind when he might have been cross—these are the most effective agents.

But these human agents need the assistance and support which comes from a carefully planned effort to gain public endorsement. The means to this end are so familiar that many of them may be listed without comment and only a few innovations need appraisal.

Newspapers. We plan in New Orleans for eight two-column feature stories per annum with approximately one short news story per week. Different types of stories are run in different papers. Stories intended to reach our patients are run in the cheaper afternoon papers. Stories planned for the contributors are reserved for the leading morning paper. Articles designed to reach business men are released for Monday rather than for any other day of the week. This year the "Ask Me Another Column" ran a series of questions on the maternity service and a special woman's column, "Eve Up-to-Date," discussed the convenience of our hourly nursing. The society page chattily discussed the organization of our woman's auxiliary. It all helps.

That the papers give space gladly is due in part to our effort to understand the point of view of the journalist who wants primarily news and interesting stories, but who is willing to accept in lieu of the "sob stuff" a "true to nature" story that does *not* exploit. And we have cultivated the cub reporter—not merely because he may some day become a writer of special articles but because assistance to him is assistance to the city editor, whose good will is an indispensable asset. We keep at least one newspaper man on the Board and on an active committee when possible. If the interest of the newspaper man is real, space follows.

Trade journals and local magazines are also successfully used. This year the baker's, the druggist's and the grocer's journals have each carried an illustrated article, each article stressing the relationship between that particular group and the Child Welfare nurses. "New Orleans Life," a semi-social magazine, also carried a feature story on "Bees and Babies," readable, but frank propaganda.

By Mail advertising is too expensive to be frequently used, but once a year a service report is published and mailed with a letter to a selected number of big givers; a bulletin and a letter of appreciation are sent to all Chest contributors who designate the Child Welfare Association. Four times a year a bulletin is issued by the Woman's Auxiliary and occasionally a special letter is sent to a selected group of public employees; *e.g.*, the policemen, the firemen, motormen and conductors. It is difficult to estimate the value of this type of publicity. We have not felt justified in discontinuing it, but we have had no tangible proof of its value.

Exhibits. Once a year, during the Chest drive, every agency is allotted space in the window of one of the department stores. The exhibits are too expensive to be used only during the three days of the Chest publicity. We have therefore made two uses of our window displays. They are moved to windows of vacant stores and kept on display until they cease to draw a crowd or they are sent down to our permanent exhibit space in the International Trade Exhibit Building. The present exhibit, an electrical map with two supplementary colored panels, has attracted widespread attention. This is a form of advertising which we plan to push for the coming years until it palls.

Public Speaking. Perhaps the most satisfactory method of reaching the people is through talks before small groups, where informal discussion may follow and illustrations can be given by slides, charts or by nursing demonstrations. The latter are certain to awaken interest and enlist new supporters. In 1928, from January to April 15, the Child Welfare Association met 21 such groups.

Moving Pictures. Theaters will usually carry a limited number of slides without charge and these can always be used to advantage, particularly in advertising hourly or contract nursing.

EDUCATIONAL DIRECTORS' LUNCHEON—TECHNIQUES

TEACHING

By Ruth Morton, Assistant Director, Instructive Visiting Nurse Association, Richmond, Va.

Thorndike's Principles of Teaching say that the first law of learning is "Readiness" or "Set to go." We, in the Instructive Visiting Nurse Association of Richmond, Va., employ that principle with our students the very first day.

We affiliate with the School of Social Work and Public Health, under the College of William and Mary, by providing for their students a practical field experience under close supervision. We affiliate with one local hospital, giving senior nurses two months practical experience. The new members of our own staff have the same preliminary period of intensive instruction and supervision.

We take into consideration the preliminary training and background of each student. The affiliated groups have varied and some have limited experience in nursing. Senior student nurses from the hospital must have had all their services including obstetrical and pediatric nursing to qualify for the practice field.

Experience has taught us that a brief crowded period of observation and demonstration confuses the student. At present, our introductory period of demonstration must be covered by the second week. The education of the staff nurse, of course, continues past this demonstration period.

The students are welcomed by the executive director, who outlines our aims and policies. The nurses are then introduced to the staff and each student is assigned to the care of an efficient staff nurse, who, utilizing the principle of interest, takes the student off for a day's observation in the field. She is sent as a friendly visitor and helper, and is instructed to ask any questions about the work.

The second day, students are taken through the offices and demonstration rooms to learn our housekeeping plans, followed by an introduction to the field and a consideration of functions.

Realizing that most of us have a visual rather than an auditory memory, we cover in our demonstrations the principal nursing procedures that would vary from hospital routine, particularly stressing organization, and giving the new nurse something very concrete. The initial demonstrations are given in a room equipped with the simplest devices, most of which are usually found in the average home, or can be improvised.

At this conference the nurse is shown how she branches out from the bed patient confined within four hospital walls to the family as a unit, that she approaches her homes not only as a nurse but as a friend and teacher with unequaled opportunity for health instruction, for health supervision of each member, and for the prevention of disease.

The medical and social resources of the city are explained. The students from the School are given a preliminary period of excursions to these agencies before coming to us, and our nurses have excursions interspersed with field work at the convenience of the agencies visited.

The nurse is then introduced to her experience sheet which she keeps for her practice period. Demonstrations include: Bag technique, general bedside care, communicable disease, post-partum, newborn, prenatal care and delivery.

The students attend the weekly staff conference, which may be a discussion of problems and policies, presentation of case histories, or special lectures and discussion of subjects of general interest to the group. Field assignments are made, preferably beginning with a chronic case, following observation and demonstration.

By the fifth day a well organized carried maternity case is visited and cared for, followed as usual by case and record conference.

New and sustained interest appears when early in the second week the prenatal conference demonstration is given. We stress the aims of prenatal care, the city resources and coöperation. She is given the essentials of a prenatal nursing visit, which comprises the usual check-up of the physical condition of the expectant mother, and, in addition, is given a printed outline for her own use and instruction.

The nurse is now assigned certain cases of various types, which are her own responsibility, and her time is now divided between active care of these cases and conference about them for her general education.

At least two supervisory visits are made

each month, and a definite standard of supervision is followed. A conference is then held with the student, who is told of her strong points and deficiencies.

Staff nurses who have been with us for one year are granted an extra afternoon each week for the purpose of enrolling in a class at the School of Social Work and Public Health, and may be granted leave of absence to complete the Public Health course.

ETHICAL

By J. Martha Kessler, Obstetrical Supervisor, Visiting Nurse Association, Milwaukee, Wis.

Relation of nurse to patient—There should be confidential relationship regarding the history of illness and social problems—friendly, sympathetic but never personal. Respect should be both felt and shown towards the patient's religion and racial characteristics, such as preparation of foods, mannerisms of dress and speech. The nurse should guide and direct the patient in every way toward better hygiene and way of living, but in each instance disturbing as little as possible any racial practice or custom peculiar to his group.

Relation of nurse to physician—The nurse should never diagnose an illness to a patient nor prescribe a medication, never discuss a physician's method of treating a patient with the patient, or with other workers (exception—the nurse's supervisor), never discuss problems of one patient with another patient, never advise any one physician or encourage patient to change physician, and be most careful to report any abnormal symptom to clinic or to the physician.

Relation of nurse to her association—To her co-workers, supervisors, directors and the board—the association as a whole—the nurse should show perfect loyalty. She should also show loyalty and responsibility to other nursing organizations, such as her alumnae, local nursing groups, committees, Red Cross, and the N.O.P.H.N.

Her relations also include other workers outside of her own association, viz.: social worker, teacher, priest, minister, other nurses.

In order that the best work may be accomplished by any nursing organization, it is absolutely necessary that a spirit of honor and devotion, a loyalty to the profession and to its codes, prevail among the staff nurses. No discord, fault finding, or personal jealousy should exist, as this will lower the standard of the work which the association is trying to do.

SOCIAL

By Clara B. Rue, Educational Director, Public Health Nursing Association, Louisville, Ky.

It would seem profitable in public health nursing to employ an educational plan of procedure in the social phase of our work just as we have developed definite techniques in nursing procedures.

Our objectives may be:

To establish a friendly and working contact with the patient and family.
To become acquainted with the family relationships, standards, and their influence on the family group.
To help the family in the adjustment of social difficulties.

To establish a friendly and working contact with the patient and the family requires special thought in making our selection of nurses for the staff. We find the personality of the nurse plays such a singular part in the success or failure of her work that a nurse appointed to a position on the staff who does not get along well with people may injure the work of the organization very greatly. Thus a study of her qualifications from the social angle as well as the nursing is indicated before a permanent appointment is made. Most of the nurses filling staff positions have not had the opportunity of formal study in social subjects, their social interest being developed through practical experience. We need to promote this social interest into a broader social vision, including a consciousness of the problems of society, the family and the individual. Without doubt we have as definite a problem and obligation in creating a social point of view as we have in establishing and maintaining a public health point of view.

The second objective, to become acquainted with the family relationships, standards of living and influence on the family group, has an outstanding effect on the quality of our

health work in the home. We engage in a great deal of unproductive health teaching unless our teaching is planned with a picture of the individual family in mind. In a technique designed to guide us in our social work the nurse should have a better understanding of human behavior and consequently avoid many failures in promoting health practices.

In the third objective, our responsibilities take a new form—to help the family in adjusting its social difficulties either through advice or through the channels of other agencies. The city, county, and state in all parts of the country are well endowed with social agencies of various kinds and social legislation in many forms. Individual members of society in the main know very little of the resources at hand. Thus, it is definitely a duty of any social worker, the nurse included, to acquaint the family with the resources available. This entails a two-fold power of understanding. First, the nurse must be able to recognize family problems and second, she must be familiar enough with agencies prepared to handle the problem to direct the family to the proper source.

A successful program of work can only be attained through analysis and organization of procedures within our own organization. It should not be the work of one individual in the organization, but a group mind. This group working in the field of public health nursing through their analytical study, will produce the essential elements necessary for a practical social technique.

STATE BOARD OF HEALTH SUPERVISORS

At the luncheon of State Board of Health Supervisors, June 5th, the following motion was passed:

It was recommended (a) that the conclusions reached at Atlantic City following a series of conferences with directors of nursing in state departments of health and the staff of the N.O.P.H.N., be published in THE PUBLIC HEALTH NURSE; (b) that they be presented to the State and Provincial Health Officers for approval.

The conclusions, read by Theresa Kraker Guthrie, follow:

ORGANIZATION

1. *Agreed*, that there should be a bureau, division or department of Public Health Nursing in the State Department of Health with a nurse as the director who will be directly responsible to the executive officer of the State Board of Health; and that in states where there is no provision made by law for creating a bureau of Public Health Nursing, a law creating a bureau, division or department is advisable.

2. *Agreed*, that the bureau of Public Health Nursing should give an administrative service to all nurses employed in the State Department of Health.

3. *Agreed*, that the relationship of the bureau of Public Health Nursing shall include both advisory service to other bureaus or divisions and the responsibility for executing the nursing program of the other bureaus or divisions.

4. *Agreed*, that the State Department of Health also serve as a clearing house for Public Health Nursing in that all Public Health Nursing services, whether public or private, present their programs and file reports as requested to the State Department of Health in order to help perfect a uniform organization for Public Health Nursing in the state; and that a uniform type of report be developed for the use of a nurse on a local piece of Public Health Nursing work which will be satisfactory to all the agencies concerned.

5. *Agreed*, that the various supervising nurses of public and private agencies should confer at intervals and come to an agreement concerning the supervision of a particular local Public Health Nursing service and thus avoid multiple supervision where a service is supported by a combination of agencies.

6. *Agreed*, that the conclusions of this conference be sent to the organizations represented at this conference.

EDUCATION

1. *Agreed*, that the Public Health Nursing bureau, division or department of the State Department of Health should adopt a program of continuous education for all public health nurses in the state. Such a program should include group conferences at least once a year, suggested reading and general encouragement of the nurse to attend recognized university public health nursing courses.

2. *Agreed*, that the Public Health Nursing service in a State Department of Health should stimulate public opinion so that official and non-official agencies within the state will

employ only properly qualified nurses for state and local pieces of work and that those nurses be paid adequate salaries.*

RELATION TO VOCATIONAL SERVICE N.O.P.H.N.

1. *Agreed,* that the State Department of Health having a distinct Public Health Nursing service with a nurse director would be the logical body to serve as the cenral agency for placement work throughout the state. The N.O.P.H.N. in its vocational and placement capacities stands ready to assist this central agency as much as possible.

2. *Agreed,* that the state agency should acquaint the local organization with the part the N.O.P.H.N. had in helping it secure its nurses.

STAFF EDUCATION

Mathilde S. Kuhlman, Director, Division Public Health Nursing, New York State Department of Health

In 1925 when extensive maternity, infancy and child hygiene activities were initiated in New York State, a great need was felt for a teaching center where public health nurses might learn standardized methods to carry on maternity infancy work and where systematic record keeping could be taught. The most important factors in establishing a teaching center were finding the place where the infant and maternal mortality rate was high and the work most needed; where the physicians were in accord with establishing a child hygiene station and teaching center and where the nursing service was not adequately supplied by the local community. A very important consideration was also finding the nurse who could successfully carry on the work.

The teaching center was established in Fulton, N. Y., where the population is 12,571. Extensive woolen mills furnish occupation for many of the residents including men and women. The first year was spent in establishing the child hygiene station and in familiarizing the community with the work. The nurse who was assigned had previously been on the staff of the Maternity Center Association, New York City, for some years and she was therefore familiar with the details of maternity and infancy work. After a year's time the teaching center was developed at the child hygiene station and a nurse instructor secured to carry on that phase of the work. Two other nurses were assigned to assist and to carry on the home visiting and group teaching.

Each nurse appointed on the state staff spends from two weeks to a month at the teaching center depending upon her previous experience in child hygiene work. The center is available to nurses throughout the state from any organization wishing to send its nurses. In order to make the teaching effective it is desirable that nurses remain one month. The expenses besides the railroad fare amount to $15 a week for room and board in Fulton. Home visits are made under supervision. Conferences are held for infants and preschool children; family health conferences and Little Mothers' Leagues are taught; prenatal consultations are carried on; and occasional orthopedic clinics are conducted at the center and nurses attending the center are required to do a certain amount of reading bearing upon the work.

Application is made through the Division of Public Health Nursing, State Department of Health, Albany, N. Y. During 1927 and up to the present time in 1928 fifty-seven nurses have been instructed at the teaching center. An efficiency report of each nurse is sent to the Nursing Division after the nurse has completed her work.

Jessie L. Marriner, Director, Bureau of Child Hygiene and Public Health Nursing, Alabama State Board of Health.

Miss Marriner, speaking on staff education in relation to the state nurse, said in part that public health nurses learn by doing. A training center is maintained in Alabama with a staff of one public health nurse, one county health officer, one sanitary inspector, and one office secretary. The nurse in training actually goes into the field and does the

* Qualifications for public health nurses are those outlined in the Report of the Committee for Formulating Standards for positions in Public Health Nursing.

real nursing under very close supervision. Four to six nurses are trained at a time. They are very carefully selected and if after four weeks they do not prove satisfactory they confer with the director and are dropped from the service.

Ada Taylor Graham, Director, Bureau of Child Hygiene and Public Health Nursing, South Carolina State Board of Health.

Whether a nurse has had her initial public health training in a university school or a teaching center or a combination of both, it is necessary that some method be devised by which she may continue her public health education after she has taken up her work.

This is a far more difficult task in rural districts than it is in a city. In some instances the county home demonstration agent may furnish coöperation that is helpful, and occasionally a second nurse or social worker is employed by the county tuberculosis association or Red Cross Chapter, but in our state these are the exceptional counties. To give to these nurses educational opportunities we have made use of the following:

Circulating library.
Quarterly meetings of health officers and nurses.
Annual institute.
Advisory service.

Quarterly meetings. Every three months we have an all day meeting of health officers and nurses. The morning session is given to papers on subjects of general or special interest and in the afternoon the group usually divides into two sections, doctors and nurses, and the current problems are discussed.

Annual institute. For the past five years we have held an annual institute for public health nurses. During the first three years this institute was of two weeks duration and was a part of our four months' field course. The last two years we have had three day institutes attended by all the county and city nurses.

Advisory service. We would like to have a group of specialists in each line of health work, but since our funds are limited we have tried to develop a good general service by selecting for our advisory nurses only those who, on a foundation of pleasing personality, a sufficient cultural background and ability to teach, have added good professional training and broad general experience.

These advisory nurses have from six to nine counties. They visit the county nurses at regular intervals for a week or ten days and answer any special calls for assistance including special assistance to new nurses.

INDUSTRIAL NURSES LUNCHEON—DISCUSSION OF ETHICS

Wearing of Uniforms—Elizabeth Winton, Edward G. Budd Manufacturing Company, Philadelphia, Pa.

I am taking for granted that every nurse who is engaged in doing industrial nursing wears a uniform of some kind. An industrial nurse wears a uniform for the same purpose as any other nurse: to keep clean for the protection of herself and her patients; as a badge of her authority, and as a protection when carrying on her duties outside her headquarters.

Most of the industrial nurses whose duties are chiefly those of dispensary work wear white uniforms. Many of those whose duties are a combination of dispensary work and visiting in the homes wear white uniforms in the dispensary and street clothes for outside calls. Some nurses have adopted the public health nurse's uniform and I believe this is a wise selection. Industrial nurses are doing a piece of public health nursing and there is nothing which will emphasize this fact better or which will raise and stabilize standards of industrial nursing more quickly than to adopt a uniform which is recognized as the uniform of nurses who are carrying a health message to the public either through individual or group education. This is a time when we are all hearing much about expressing individuality. The industrial nurse has ample opportunity to express her individuality in professional dress and at the same time wear a uniform which has about it all the earmarks of a public health nurse's uniform.

Should the industrial nurse's uniform in-

clude a coat and a hat? I believe it should. The tailoring establishments are offering uniform coats and hats which the public health nurse can wear with a sense of not only being appropriately but professionally well dressed. The money spent for the right kind of uniforms is a sound investment which can be counted upon to pay dividends.

Obtaining Standing Orders—S. Jane Williams, Hilliard and Merrill Company, Lynn, Mass.

I believe standing orders are essential in industrial nursing not only because they are required by law in certain states but for the protection of the nurse. These can be obtained without difficulty in various ways:

No doctor in attendance—If covered by Workmen's Compensation Insurance, they may be obtained from the insurance doctor or if he refuses to give her a list the nurse can make a list of treatments and simple drugs for the relief of minor ills and accidents by referring to treatments recommended by the Red Cross First Aid Manual. After compiling this list it should be taken to the insurance doctor for his approval and recommendations. He should sign these orders if they are satisfactory to him.

Or the nurse may compile such a list and take it to one or several local doctors, who may be called on from time to time, for approval and signature. This method of obtaining standing orders has been used by industrial nurses in many instances.

Part-time doctor—May give standing orders in writing upon request. It is well to go over the list with the doctor from time to time so that the list may be kept up to date to meet the new cases and treatments.

Full-time doctor—Standing orders can be given verbally by him to cover the individual case.

Standing orders should always be kept where they can be referred to easily and not put away where they cannot be found. Even though a nurse has standing orders, it is always well to remember that it is better to call a doctor once too often than not enough, so that there will be no liability on the nurse's part.

Relationship of Nurse to Safety Committee—Marion Page, Director, Welfare Department, The Richardson Company, Cincinnati, Ohio

Until about fifteen years ago very little was heard about accident prevention. The safety movement is still in its adolescence but each year finds it increased in importance and becoming more and more an integral part of industrial life. Its success in an industry depends largely upon coöperative effort on the part of everyone connected with the plant, from the management to the individual employee. The industrial nurse owes it to herself and to the management to identify herself with this growing movement.

The first aid department has a definite place in the safety campaign. No nurse should be content to sit waiting for an accident to happen. She will be far more valuable to her company if she concentrates on helping to bring about safer working conditions in and about the plant. This can best be accomplished by maintaining a close association with the Safety Committee. Indeed her logical place is as a member of this committee.

Her first step in the program of safety should begin at the time of her first contact with the new employee, which is, ordinarily, when he reports for his first physical examination. A few friendly words on the subject of safety accompanied by a request that he report all injuries, even the most trivial, at the plant hospital, can do much to establish pleasant relations between the new employee and the nurse.

It is of the utmost importance that she keep accurate and complete records of each case reporting at the company hospital. It is not sufficient in an accident case to note the employee's name, clock number, department, type of injury and treatment given. It is essential that she ascertain the cause of the accident, not only to enable her to render intelligent first aid but also in order that she may have a complete record of the case on file for future reference and for her daily reports. Records vary in different industries, and only in the last few years has there been an attempt at standardization. Where a full-time physician is employed it is customary for the nurse to send out only such hospital reports as meet with his approval,

but where this is left entirely to the discretion of the nurse she owes it to everybody concerned to make full reports of all accidents.

Daily reports should be sent to the operating manager, the chairman of the Safety Committee, and all department heads. A lukewarm attitude toward making adequate reports is the cause of many an operating manager's lack of interest in the subject of safety. The Safety Committee has vital need of these records if its work in accident prevention is to be effective.

A monthly classification of accidents according to type, department, severity, frequency and cause facilitates analysis of the accident situation. Semi-annual and annual reports do much to stimulate interest. Comparative figures and charts showing the actual decrease in lost time accidents from year to year are sufficient proof to most managements that safety pays dividends both in increased production and in the saving of human lives.

Frequently an occasion arises for an immediate check-up following an accident in order that a hazard may be removed before another employee suffers a similar injury. In the absence of a plant physician it becomes the nurse's duty to report at once the accident and cause to the chairman of the Safety Committee. Mental alertness and the spirit of coöperation can do much toward establishing the nurse in her rightful place in industrial life.

Familiarity with the state industrial commission laws is not only advisable but necessary. Hardly a day passes without some question being raised concerning the commission's rulings. To shrug one's shoulders and deplore in a resigned manner the existence of "so much red tape" will not suffice. Far better to be able to answer intelligently.

Frequent trips about the plant do much toward acquainting the nurse with the various jobs and the hazards accompanying them. This knowledge facilitates the making of brief, concise statements of the causes of accidents, and is necessary if the nurse is to maintain satisfactory relations with the Safety Committee.

In justice to the employer it is advisable to take the temperature of any employee reporting at the hospital with a vague complaint of "strained" back or side but with no definite history of injury. This practice has been of inestimable value in reducing the number of compensation causes, leading, as it may when there is an elevation of temperature, to a correct diagnosis by the examining physician.

Relation of the Nurse to the Personnel Department—Mary Elderkin, Medical and Service Department, Union Carbide Company, New York City

At the time of the physical examination for employment we have the first opportunity for a contact between the medical and personnel departments, which should result in a wise decision as to the employment of the individual. The medical department can do more than say whether or not the person is physically fit. It can become acquainted with the facts relative to the job for which the worker is being considered, and aside from simply reporting back to the personnel department as to his physical ability for performing the work, may also bring to its attention any other details of character, personal habits or idiosyncrasies that are apparent and that might be undesirable from the employment standpoint.

Another opportunity is in the case of an employee who is under treatment for some serious condition. All of the factors pertaining to his work should be available to the doctor or nurse and decision as to the disposition of the case should only be made after consultation with the department head and personnel department. At the same time the personnel department may be acquainted with the possible length of disability, and so be assisted in determining whether or not it is going to be necessary to permanently fill the job.

The medical department has endless opportunities for interpreting to the sick or injured employee the policies of the company as they are being carried out by the personnel department, and in order to do this must be thoroughly familiar with these policies.

To me the functions of the two departments seem to dovetail so closely, that if they were to be carried on in an ideal manner the dividing line would scarcely be

apparent. This close coöperation would result in:

Selection of the best equipped personnel physically, mentally and temperamentally for the work to be done.

Maintenance of personnel in the best possible physical condition and provision for adequate care in case of accident, as well as assuring a contented group of people by carefully considered promotions, transfers, or eliminations based on the health history as well as the general efficiency.

Because of this mutual understanding between the two departments they would be able to serve the employees in such a manner that they would turn to them for advice and guidance on questions pertaining to their work, health or personal affairs, and time and effort would be saved in dealing with most of the problems when unsatisfactory employment relations exist.

If we would all keep in mind the common object of service to both the company and the employee there would be little time for any but the most harmonious relations between all members of the medical and personnel departments.

The report of the luncheon meeting of the School Nursing Supervisors will appear in the September magazine.

MISS FOLEY HONORED

At the fiftieth Commencement exercises of Smith College the degree of Doctor of Science was conferred upon Edna Lois Foley, Director, Chicago Visiting Nurse Association, of whom President William Allen Neilson in conferring the degree said:

"Edna Lois Foley, graduate of Smith College of the Class of 1901 and of the Hartford Hospital Training School for Nurses, Superintendent of the Visiting Nurses Association of Chicago, the largest organization of its kind in the world, a skilled nurse and teacher of nurses, a wise and rigorous administrator, an authority on public health and social welfare, a large hearted and keen sighted student of human nature."

In the 53 years of its existence Smith College has granted only 57 honorary degrees. The degree of Sc.D. has been given by Smith College to only seven others besides Miss Foley: Ellen Henrietta Richards, Dr. Florence Rena Sabin, Dr. Ellen Gleditsch, Mme. Marie Curie, Sir Robert Jones, Dr. Florence Gilman and Dr. Alice Hamilton.

Our attention has been drawn to an error in the June PUBLIC HEALTH NURSE. On page 321 the Brooklyn Visiting Nurse Association student affiliation for pediatric training with three hospitals in Brooklyn should have read that the course has been under way since 1926. It is given from September to June to groups of six or seven student nurses rotating at six weeks intervals. It is intended to supplement the hospital training in the care of the sick child and also emphasizes the development and care of the normal child. Theory as well as practice is a feature of the course.

Some day we may be tempted to send to a contributor the following letter, which was used by a Chinese publishing house in returning a manuscript:

"We read your manuscript with boundless delight. By the sacred ashes of our ancestors we swear that we have never dipped into a book of such overwhelming mastery. If we were to publish this book it would be impossible in the future to issue any book of a lower standard.

"As it is unthinkable that within the next ten thousand years we shall find its equal, we are, to our great regret, compelled to return this too divine work and beg you a thousand times to forgive our action."

REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

NURSES, PATIENTS, AND POCKETBOOKS

Report of A Study of the Economics of Nursing Conducted by the Committee on the Grading of Nursing Schools

May Ayres Burgess, Director. Published by the Committee on the Grading of Nursing Schools. New York City, 1928. Price $2.00.

Nurses everywhere may congratulate themselves upon this book. Its statistics, testimonies, stories, charts, bold-type comments and fine-type appendices will serve them, their allies and their critics for years to come as a foundation for discussion, a basis for coöperation, and an opportunity for plan-making.

The general public (and some nurses) may be amazed to learn that while it is paying $6 or $7 a day for a private nurse, nevertheless private nurses are earning an average of only $1,300 per year, because a third of their time is spent in waiting for the next job or in being sick. Those who have complained of a shortage of nurses or who advocate more training schools and shorter and cheaper nursing courses, will find it difficult to maintain their ground in the face of the piled-up facts which Doctor Burgess and her colleagues have marshaled.

The Committee and Doctor Burgess are to be congratulated on having secured such ample testimony from physicians as well as from nurses themselves. Are doctors satisfied with nurses? Read Chapters 8 and 9 and find out. Are patients satisfied? Read Chapters 9 and 10. How do nurses like their jobs? Statistics and testimony from several thousand nurses are in Chapters 14 and 15.

The book is a study of the economics of nurses rather than the economics of nursing as its title states. It would be desirable that the Grading Committee focus the minds of some economists of standing upon Doctor Burgess's data concerning earnings, employment and distribution of nurses.

The trend of the book is to face hospitals with the demand that they cease producing nurses in training schools run largely for purposes of the hospital, rather than as educational institutions, which adjust their standards and size of output to public needs. The challenge is not a new one, but many facts are new and they present the hospital world with difficult nuts to crack. The current belief that it is much more economical to run a hospital with a training school than with graduate nurses is again questioned, although a demonstration sufficient for most hospital executives and trustees will not be found in Doctor Burgess's volume and needs more working up from the hospital and business standpoint, before a case convincing to those not easily convinced can be made.

Nurses may well feel pride in the distinguished body of their own and coöperating vocations which is searching into matters so fundamental to their welfare, and in a contribution so sympathetic, so disinterested and so significant which contact with their own beloved profession has inspired in the director of the study, herself not a nurse.

MICHAEL M. DAVIS